

NAVY MEDICINE

January-February/March-April 1989



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NAVY MEDICINE

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COVER: Thirty-five years ago, following the French defeat in Indochina, the U.S. Navy took part in one of the largest humanitarian operations ever mounted. During "Operation Passage to Freedom," Navy ships and personnel helped transport over half a million refugees from North to South Vietnam. Story on page 26. Official Navy photo.

Innovation Is for Everyone

Innovation is the lifeblood of any modern organization in a rapidly changing society. The old ways are not necessarily the best ways, and change has become our constant companion whether we wish it or not. The competitiveness of modern military medicine in providing a wide range of care, worldwide, under challenging conditions demands that we seek out the newest and best ways, and apply the fullest measure of resourcefulness to everything we do.

When I wrote the CHARLIE GOLF ONE message on Innovation in June 1988 (CNO 011619Z JUN 88), we were in the early stages of bringing improved management practice and organization to our Medical Department. Subsequently, the findings of the Blue Ribbon Panel on Medicine chaired by the Vice Chief of Naval Operations gave further impetus to our need to find new and better ways. We can look forward to further refinements and improvements of our methods in the years ahead, most of them the product of our own people—those who know Navy medicine best, and how best to make it work better.

We are starting out well equipped for the task, with an enormous reservoir of intelligence, resourcefulness, and capability in each of our corps. A great feature of innovation is that everyone can be an important participant in the process. Improvements which can be made span the entire range of medical endeavor. No one is left out of the excitement of seeing his or her own contribution brought into practice when it will improve our capability.

It is essential that we have an environment in which new ideas can flourish, grow, and continue to be developed. Everyone must understand that we can no longer afford to reject ideas because they were "Not Invented Here." Good ideas come from all ranks, all rates, all corps. We must be perceptive in recognizing a good idea when we see it, encouraging our people to bring them forward, and publicly rewarding innovators to recognize their achievement and to encourage others. Being as it is the wave of the future, and an essential ingredient in improving the Medical Department of the future, each of us must not only accept innovation as necessary, but also be personal participants in bringing about innovative change and improvement.

VADM James A. Zimble, MC

A look back: Navy medicine ca. 1917



NAVMEDCOM Archives

Ambulance crew, Naval Hospital, Chelsea, MA

Innovation

The Application of Brainpower

This issue carries a message which has great import for the future. Innovation as a way of life is the key to the success of Navy medicine in the highly competitive years to come. Enormous change has already taken place, with the Medical Department becoming a major claimant for funding and personnel with the return of the CHAMPUS program to the military services. As a multibillion dollar, 50,000-person organization, we must recognize the role of change and improvement . . . INNOVATION . . . in our continuing effort to best utilize our resources in a time of limited budgets.

Innovation is not change for the sake of change. Rather it is the proactive application of brainpower systemwide to the improvement of everything we do. Essential to its success is the communication of improvement throughout the system, so that ideas developed in west coast hospitals can be promptly shared with our people throughout the Continental U.S., Europe, and WESTPAC.

Harnessing good ideas systematically, giving credit to their authors, and encouraging adaptation of procedures to fit the different locations throughout our system will bring us enormous benefits in every area of our endeavor. There is no part of Navy medicine which does not have great potential for improved procedures and ideas. Innovation is a science of the positive, and accepting innovation as not only the art of the possible, but indeed the art of the essential, is important to us all.

CAPT Bob Zentmyer will be the Innovation Coordinator for Navy medicine, working here at NAVMEDCOM with others to support his efforts. You will be hearing from him, and I know that you will soon see convincing results. Sharing of information and brainpower has never been more important to us, and the prospects for expanded successes in this area are one of the most exciting developments we have to look forward to in the months and years ahead.

RADM H. James T. Sears, MC

U.S. and Thai dentists work together treating dental patients in a Ban Yai Da schoolroom. There were a number of curious onlookers.



Department Rounds

U.S.-Thai Armed Forces Bring Medical Aid to Villagers

The success of a joint exercise like Cobra Gold '88 can be measured a number of ways. The sheer number of troops, ships, planes, tanks, and other heavy equipment mobilized for the exercise provide valuable experience to the troops and information for the logistical planners.

For LT Tim Butson, 3-year-old Narong was the most important person in the world for a moment. Narong's mother soothed her son by stroking his feet while Butson, a Navy dental officer, injected an anesthetic into Narong's gums. Butson winced as much as the child, trying to make the injection as painless as possible. With-

drawing the syringe, Butson motioned his surprise to a nearby dental technician, holding up three fingers and mouthing the words, "Only 3 years old!" Narong still hadn't shed a tear.

"These are a very stoic, disciplined people," LT Butson later said of the many Thai villagers he treated. "The children are very strong."



JO1 Patrick E. Winter

LT Butson was part of a U.S.-Thai medical team that saw another 45 patients that day in the southern Thai village of Ban Yai Da, the scene of three separate U.S. Navy-supported civic action projects only miles from the beaches of the combined U.S.-Thai amphibious assault of Cobra Gold '88 in the Rayong Province.

Cobra Gold '88, the seventh in a biannual series of military training exercises uniting U.S. and Royal Thai armed forces, was designed to strengthen the total defensive arm of Thailand. Under a civic action program utilizing Cobra Gold military personnel, seven Thai villages in the Rayong area benefited from medical and dental care, and school textbooks and supplies from Project Handclasp. Construction of a water tower was directed by Navy Seabees and built by local Thais.

But only at the small primary school at Ban Yai Da did all three projects occur simultaneously.

"What we're doing here is real," Navy Senior Chief John Ludlum said. Senior Chief Ludlum, a Seabee heavy equipment operator, was one of two Seabee advisors who directed the

replacement of a simple hand water pump with a 4,000-liter water tank and a one-horsepower electric water pump near the Ban Yai Da school. "When Cobra Gold is over, all those ships are leaving," Ludlum said. "But this water tower will be here forever."

The projects were designed to provide the type of help the people wanted. CDR William H. Steussy, USN, the Thailand point-of-contact for Project Handclasp donations, visited the Rayong medical clinics and schools earlier this year to see what was needed.

"To give you an idea of how it went," he said, "I saw a doctor sharpening a hypodermic needle against a rock. He only had four reusable needles. When I asked him what he could use, he said, 'Well, we could use some more of these.' So when I went to Project Handclasp, we were able to provide 500 reusable glass syringes and 1,000 throwaway syringes for the clinics. Besides that, we gave the clinics pressure cookers to sterilize the needles at 250° F.

PHC Chet King



Royal Thai Navy nurses and U.S. Navy corpsmen look after a youngster during a medical civic action project (MED-CAP) in Rayong, Thailand, held in conjunction with Exercise Cobra Gold '88.

"The modern conveniences we take for granted in the United States aren't practical in Thailand. You're going to see a lot of smiling faces out there," CDR Steussy told the Project Handclasp volunteers.

HMI Jeff Curtis did. A corpsman from the USS *Mobile* detachment of the 1st Field Services Support Group, Camp Pendleton, CA, Curtis volunteered to help distribute Project Handclasp materials. It was a feeling he would not soon forget.

"If every American could just see how people in this part of the world live, they would soon realize what we're doing is well worth the effort," Petty Officer Curtis said. "To give a child a toy—who has never had one before—is one of the greatest feelings in the world."

Under Project Handclasp, a U.S. Navy-supported humanitarian aid program, more than 30,000 pounds of products were donated by U.S. companies and transported to Thailand. USS *Mount Vernon* first shipped an advance load in February and USS

Mobile brought the rest during the Cobra Gold '88 exercise.

This year, Steussy pointed out, the Handclasp materials included a variety of medical, school, and orphanage supplies. In addition to the syringes

there were 240 cases of Anacin III and Children's Anacin III, 11 cases of toothbrushes and hygiene kits, textbooks, pencils, and for recess time, frisbees, skateboards, soccer balls, and volleyballs.

Children were quick to welcome the sailors and marines. While the boys jumped on the skateboards and chased frisbees, the girls would bow and curtsy and show visitors their reading skills.

The Project Handclasp medical supplies supplemented the medical supplies from the joint U.S.-Thai mobile medical team that opened its first of seven medical aid stations in Ban Yai Da, before moving on.

Butson, from the Okinawa-based 3rd Field Services Support Group, was officer in charge of the U.S. Navy and Marine Corps team of medical specialists, 16 in all, including two physicians and one other dental officer. The U.S. team linked with a Thai medical team of 24.

"Our job was to augment the Thais," Butson said. "We were out there to assist in providing definitive and preventive medical treatment for the Thai people, as well as to learn.

"We were learning from the Thais because they're experts at treating health problems associated with a tropical environment," Butson said. Altogether, the U.S.-Thai medical team provided free health care and treatment to close to 1,500 Thai citizens.

Despite the "mobile" tag, the medical team was not under-equipped. The team was outfitted with a full-blown chemistry lab for on-scene blood tests, one oral X-ray unit, and three portable dental chairs. Once set up, the team would begin seeing villagers immediately and continue all day long.

"That was important because most Thai families are extended families," Butson said. "By seeing the mother, we were assured of seeing her children and older members of her family. We stayed open until the last patient."

The medical problems treated by the U.S.-Thai medical teams were mostly influenza, gastrointestinal disorders, and childhood diseases that required on-the-spot dispensing of drugs from the field pharmacy.

The pharmaceutical supplies were brought under the U.S. Title 10 Congressional Funding Program, providing \$10,000 earmarked for the joint U.S.-Thai medical team. The main stipulations were that the money be spent for humanitarian purposes and spent in-country, meaning buying Thai medical products.

"It took us 3 days, working with Thai nurses at the JUSMAG (Joint U.S. Military Assistance Group, Thailand) in Bangkok to procure exactly \$10,000 in medical supplies," Butson said.

Title 10 funding also financed the water tower project in Ban Yai Da, which was completed at a cost of about \$5,000 according to Senior Chief Ludlum. □

—Story by JO1 Howard Samuelson, USNR, PACEN San Diego NR Det. 119.

JO1 Patrick E. Winter



Royal Thai and U.S. marines and sailors distribute Project Handclasp's \$30,000 worth of medical, school, and orphanage supplies to seven villages and clinics.

JO1 Patrick E. Winter



HM3 Albino Decastro from 3rd Field Service Support Group, "C" Company, 3rd Medical Battalion, is curiously watched by Thai youngsters as he examines blood samples.



RADM Shaffer Retires

Chief of Naval Operations, ADM Carlisle A.H. Trost, presents RADM Shaffer with the Navy's Distinguished Service Medal at the latter's recent retirement.

Interview

On 1 Feb 1989 RADM Richard Shaffer retired after serving 28 years as a Navy dentist, and the past 4½ years as the Chief of the Navy Dental Corps. RADM Shaffer was truly multihatted, serving also as Deputy Director of Navy Medicine for Dentistry, Deputy Commander Naval Medical Command for Dental Health Care Operations, and, on paper at least, Chief of the Dental Division of the Bureau of Medicine and Surgery.

In one important assignment RADM Shaffer was a pioneer for the Navy Dental Corps. When selected to command the National Capital Region in 1984, he became the only dentist ever to command a geographic region. He was also the first Navy dental officer to hold the rank of commodore.

Navy Medicine recently talked with RADM Shaffer as he reminisced on a long, distinguished and self-proclaimed "fun" Navy career.

NAVY MEDICINE: What have the past 28 years been like?

RADM Shaffer: I have had all the fun billets the Navy Dental Corps offered. I've served aboard two ships, been stationed at the Naval Academy and overseas in Panama and Spain. I had command of the clinics at Great Lakes and Norfolk. I have been a fleet dental officer, and I feel somewhat unique and privileged to have been the first dentist to have commanded a geo-

RADM Shaffer briefs the dental department in the ready room of USS Coral Sea (CVA-43) and (below) tours the Japanese Naval Academy.



graphic region and the only nonphysician to have commanded the National Naval Medical Center.

What were some of the issues that involved you while you were commander of the National Capital Region?

The tower refit, the construction of the new enlisted barracks, the profitability of the Officer's Club, the support we gave the University [Uniformed Services University of the Health Sciences (USUHS)], and the interaction with the city [Bethesda].

It was also a difficult time. There was the Billig case and then some tough congressional issues. There were two surgeries for the President and major surgery for Mrs. Reagan. Needless to say, there was a lot of attention focused my way.

What have been some of the great contributions of Navy dentistry during your career?

In dentistry we have seen the most successful preventive program ever established with the prevention of caries. I look at my sons' teeth and they are amazingly better than mine. We did it with fluorides and the Navy was a leader in providing fluoridated water on our bases.



Is the profession putting itself out of business because of its successes?

I don't think so. There are still problems to solve. Caries has not been eradicated even though it appears to be lessening. We can show this in our studies at boot camps conducted by the Naval Dental Research Institute (NDRI). Periodontal disease is still rampant. Trauma will always be with us. Why do abscesses form? I don't have an answer. It's predicted that we'll have a caries vaccine someday, but that has been said for 20 years.

We are now seeing some interesting trends. Since we can now maintain teeth longer, there's no longer any excuse for not maintaining a tooth in your mouth. For nerve involvement, we have endodontics. We can treat periodontal disease. In some cases we can even reimplant teeth that have been knocked out.

We are observing something in the elderly we've rarely seen before—decay. That's because the teeth were never there at such advanced ages. Maintenance of dental health is something we must continue to reinforce. With all this work to do dentists will not go out of business for a long time.

Is the Navy in a good position to do a lot of this work?

At this time, the Navy Dental Corps does not have the resources even to do comprehensive dentistry on the active duty population. Studies show that we

need many more dental officers, technicians, and hygienists. We are contracting for hygienists now for the first time. We're also looking into contracting for technicians to make our dentists more efficient. The Dental Corps is not unique as to its needs; it is resource-limited as is the rest of the Medical Department.

I had a full crown installed the other day, and I was truly amazed to see what progress has been made in alloys and impression materials since I was a dental tech some 20 years ago. I know the Navy has been a leader in dental technology over the years.

The air turbine handpiece was developed at Bethesda. We did many controlled studies in the early days of fluoride. We have done a lot of material testing over the years. And it's true that the new alloys are harder and easier to cast. Equipment, noise, the speed of handpieces, casting techniques, our ultrasonic techniques—all these have seen tremendous change in the last 20-25 years. And we've been right there. NDRI in Great Lakes is involved in some tremendous studies. They are even helping develop products outside of dentistry such as new helmets, new mouthpieces for divers, and new alloy casting technology that can even be utilized in fabricating small components for the missile industry.

Right now we are trying to get NDRI together with NASA because

we feel their space age metallurgy is so advanced we might be able to learn from them.

As a corps, we have been leaders in implantology. It's now part of our residency teaching programs and required for training programs. Implantology is now taught at all our teaching hospitals.

We like to think we're practicing dentistry at the cutting edge and doing so without compromising quality. We like to think our sailors and marines are getting the finest care available anywhere. I've seen our brand of dentistry all over the world, and we are doing good quality stuff. Oh sure, we may have a few botches now and then, like anywhere else, but when you're doing about 25 million procedures a year, you have to expect that.

Over the years I've noticed a very special ingredient in Navy dentistry, something more than mere camaraderie. Maybe cohesion is a better word for it. How do you account for that? I have thought about that a lot and I'm not sure I can articulate it. The Dental Corps is like a family unit and it's been that way since 1912. You never lose your identity as a Dental Corps officer. Most every career officer has been through the Navy Postgraduate Dental School. We're now calling it

the National Naval Dental Center. That has been a bonding place. I went through there in 1970 and to this day my class is something special. We party together several times a year. That kind of feeling—a corps feeling pulls us together.

We've also had wonderful leadership over the years. The reputation of the corps is something we take pride in as we do in our two Medal of Honor winners. Many of our outstanding dental assistants have gone on to dental school and have become dental officers. I'm not just talking about officers either. I am also referring to the dental family—reserves, active, enlisted, and civilians.

Our emphasis on education has been second to none. Our residencies are the finest in the world. A lot has to do with the prime location of the National Naval Dental Center. A student has access to three major dental schools, AFIP (Armed Forces Institute of Pathology), NIH, the National Bureau of Standards, and the National Library of Medicine.

What's the future of the Dental Corps vis-à-vis the Blue Ribbon Panel recommendations?

I have concerns about where the dental health care system fits into the new organization. I hope the organization

will always consider the bottom line—patient care. Dentists manage dentists best and that should be a given. I support Navy medicine and point out that many of the criticisms are unwarranted. The future of dentistry within the line community is favorable. That's who we serve. As medicine and technology get more expensive and the outside examines our cost-effectiveness and CHAMPUS costs continue to rise, it will be more and more difficult, no matter what the organization, to provide adequate resources to give our sailors and marines care. It's a tough issue and it's certainly not unique to the Navy.

I think we should be proud of what we've done. But we have to recognize that people are living longer. Diseases are getting tougher to cure. There are more retired people, more dependents, single parents, isolated tours, and non-sponsored dependents overseas. All this is having tremendous impact on us. And we're not going to solve these issues without more resources.

But I do feel comfortable with how Navy dentistry will adapt. We've been around, been pushed and shoved, pulled on and realigned 10 times since I can remember.

What are your retirement plans?

I have been selected to lead the International College of Dentists, an organization of about 9,000 dentists with a worldwide membership. We've just moved the central office from Miami to Rockville, MD.

I'm leaving the Navy, but I have a few family members staying aboard. I'm delighted to leave one of my sons, an MSC lieutenant, who is newly married to a Medical Corps active duty physician. My other son is on active duty in the Judge Advocate Corps. My third son is applying to be a reserve CEC. I just don't have any kids left for the Supply Corps, and I don't have any chaplains. —JKH

HM2 J. Wright



RADM Shaffer shows the Editor some memorabilia.

Innovation in Navy Medicine: What Can We Expect?

CDR William J. Lambert, Jr., MSC, USN
LT David Krieger, MSC, USN

"These are exciting times; times that represent formidable challenges to the professionalism and abilities of our health system's managers. We must cooperate, share our professional expertise and resources, and above all innovate." (1)

When the Deputy Under Secretary of the Navy (Policy) made these remarks during the 1987 American Academy of Medical Administrators' (AAMA) federal luncheon he was speaking about a relatively new approach to issues within the health services industry. Innovation has become a serious matter of discussion for health-related organizations only within the last several years, coincident with diagnosis-related groups, competition, and other resource sensitive issues.

Navy medicine was not long in meeting the challenge offered by Under Secretary Shaw. Navy medical representatives attended an Air Force Medical Services (AFMS) symposium on innovation in San Antonio, TX, in November 1987. Shortly thereafter, the Naval Medical Command was asked by our Surgeon General to represent Navy medicine in discussions on innovation initiatives with other federal medical services (FMS's) (Army, Air Force, the Public Health Service, and the Veterans Administration).

In June 1988 VADM Zimble sent a message to the Navy Medical Department leadership highlighting the importance of innovation "in making Navy medicine better." (2) This effort was followed by the release of a "grand rounds" videotape in which he and COL Theodore Oatley, USAF, MSC,* Chief, U.S. Air Force Center for Healthcare Innovation (CHI), discussed the purposes and processes associated with innovation. (3) Meanwhile, we continued working with the other FMS's on exploring ways to use innovation jointly. Also, meetings were held with military

and industrial leaders experienced in the use of innovation technology.

In October the Navy participated in an AAMA-sponsored educational session on "innovation within the federal health services." Shortly thereafter, a major step was taken toward making innovation a household word throughout the Navy Medical Department. An innovation "round table" discussion, held at the Navy Surgeon General's Conference in Leesburg, VA, revealed a wealth of ideas and success stories from many of our medical and dental activities. These innovative efforts subsequently have been cataloged and are being prepared for publication in a Naval Medical Command innovation manual. Plans are to have this document published jointly with the next edition of the USAF's *Innovator's Catalog*.

In November 1988, at the annual meeting of the Association of Military Surgeons of the United States (AMSUS), VADM Zimble joined the other federal medical service leaders in formally establishing a Federal Healthcare Innovation Network (FHIN). To support our participation in FHIN and to coordinate innovation program activities within Navy medicine, an Innovation Manager has been designated within the Naval Medical Command. Responsibility for this function has been assigned to CAPT Robert K. Zentmyer, MSC, Director, Planning and Analysis Division (MEDCOM-32).

CAPT Zentmyer feels this is a strategically desirable location for this new effort because "it is a vital component of his responsibility for conducting 'management assist visits' at all Navy medical and dental treatment facilities." He believes that "the sharing of innovative ideas and successful management endeavors can assist in breaking down barriers to excellence in Navy health care delivery." (4)

Thus, the Navy officially joins the Army and the Air Force in establishing a formal structure for guiding and managing innovation activities within their medical communities.

Since Navy medicine is now committed to making innovation a part of its management philosophy and activities,

*See COL Oatley's article on page 14.

and to working with the other FMS's in this regard, we feel there is merit in briefly examining the concept. Our approach is to highlight some of the current thinking about innovation and to relate how it fits into the challenges facing Navy medicine. We also discuss some of the development and operational aspects of FHIN.

Innovation Is the Answer

It doesn't matter what the issue is—innovation seems to be the answer. This is the theme we get from reviewing the professional literature, attending continuing education programs, and examining the popular literature. Regardless of the subject matter (economics, education, industrial competition, leadership, management, medicine, or national security) innovation is being heralded as a prescription not only for success, but also for organizational survival.

Within the health services industry, innovation is being touted as useful in various management, clinical practice, and patient care areas. Alternative, nontraditional ways of dealing with professional employees, consumers, patients, and with other health-related organizations have been particularly well discussed.⁽⁵⁾

What Is Innovation?

Like many things in life, innovation means different things to different people. Our understanding of innovation and our attitude toward accepting or encouraging it is a blending of our personality, our professional needs, and the organizational setting in which we live and work.

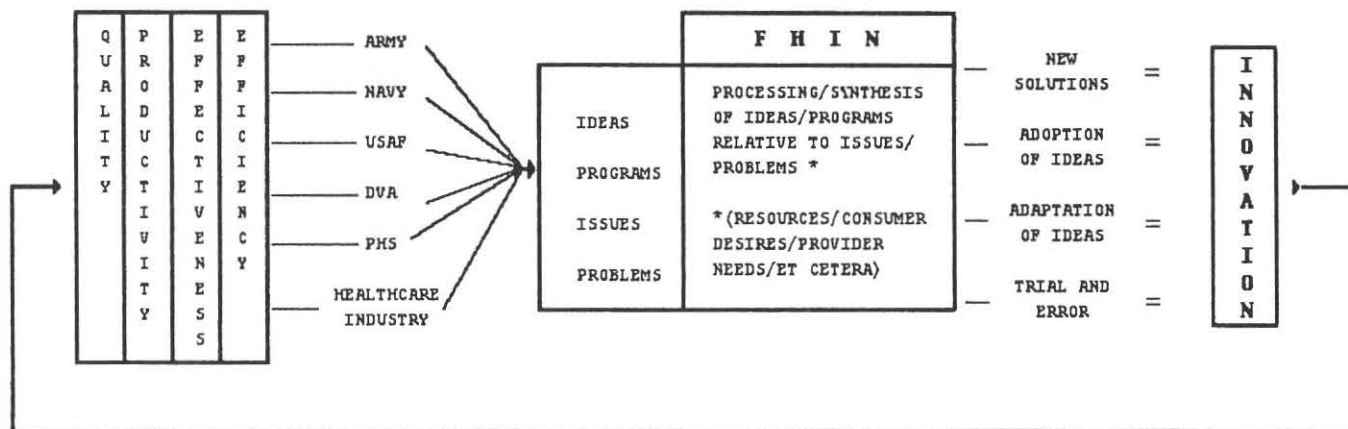
One attempt at providing an operational definition for innovation describes it "as the process of generating ideas . . . making decisions about these ideas, resulting in something useful."⁽⁶⁾ More specifically, "ideas for reorganizing, cutting costs, putting in new budget systems, improving communications, or assembling products in terms are . . . innovations."⁽⁷⁾

Traditionally, innovation has been associated with technical accomplishments, primarily within the context of the scientific and manufacturing industries. More recently, innovation has taken on broader connotations. Attention is now especially being directed to applications in computer technology and organizational dynamics. R.M. Kanter addresses this point in *The Change Masters* when she noted that "in resource-lean times, the domain for innovation simply shifts to managerial procedure and organization practice—as in the design of new ways to engage employees in solving problems."⁽⁸⁾ The reference to "resource-lean times" is obviously something with which providers of naval medicine can identify at this time.

Successful innovation programs, that is, those which provide a fair quantity of innovative suggestions that measurably contribute to the effectiveness, efficiency, productivity, or competitive position of an organization and its mission, generally share the following attributes:

- Personal attention by top level managers who exhibit "excellence"⁽⁹⁾ or "Deming-like"⁽¹⁰⁾ management style.
- Active involvement by middle managers who serve as advocates for their employee's ideas.
- Employees who have a good understanding about the mission and functions of the organization, and who exhibit loyalty, pride, and high morale.
- A large and steady stream of innovative suggestions are continuously being submitted, circulated, discussed, and implemented.
- There is quick turnaround or feedback on ideas; processing times are at the absolute minimum, and related paperwork is short and to the point.
- All innovative contributions are recognized in a timely and public manner.
- Individuals are encouraged to take prudent risks in expressing themselves and trying new approaches to problems.

TABLE 1
The Role of FHIN in Federal Medical Services



- Consumer input and dialog are valued. There is active solicitation by the organization of customer views about products and services provided, and ways to improve both. Consumer suggestions are acted upon.


Federal Healthcare Innovator's Network

Credit for the idea of establishing a Federal Healthcare Innovation Network goes to MAJ Robert Bunker, USAF, MSC, from the Air Force CHI. The final product, how-

ever, reflects the consensus of all participating FMS's. The operational concept of FHIN is illustrated in Table 1. Table 2 is a reproduction of the FHIN Proclamation Statement signed by the federal medical chiefs.

In order to attain the goals established in the Proclamation Statement, FMS's are pursuing a variety of individual and cooperative initiatives. Innovative products from these efforts are processed by FHIN and shared among FMS's members, as well as other components of the health

TABLE 2

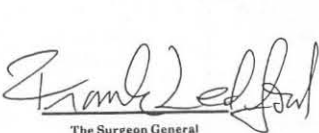



FEDERAL HEALTHCARE INNOVATION NETWORK PROCLAMATION STATEMENT

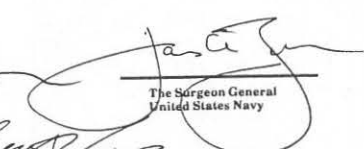
The Federal Healthcare Delivery System has created an Innovation Network whose purpose is to serve as a means to facilitate the sharing of good ideas and lessons learned between each federal healthcare agency. Further, the Network's aim is to act as a constant source of new concepts and technologies for each agency's use in enhancing operations. The Federal Healthcare Innovation Network represents a mechanism that will allow each federal agency the opportunity to work independently and cooperatively with each other to achieve a common goal of providing high quality and efficient healthcare services to all beneficiaries.

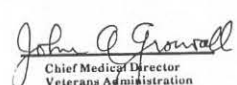
THE ATTAINMENT OF THESE GOALS REQUIRES WE COLLECTIVELY STRIVE:


<p>To heighten awareness of the need for creative ideas from all people throughout the federal healthcare organization</p> <p>To constantly pursue creative, innovative and alternative methodologies to meet the challenges of a constantly changing healthcare delivery system</p>	<p>To create an organizational climate that recognizes failure as an integral part of the "growth cycle" and welcomes change as an opportunity</p> <p>To communicate top management's commitment to encouraging and rewarding those who make innovative contributions</p>
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 The Surgeon General
United States Army


 The Surgeon General
United States Air Force


 The Surgeon General
United States Navy


 Chief Medical Director
Veterans Administration


 The Surgeon General
Public Health Service

care services industry. In this regard, FHIN joins several other efforts to tap and use the creative energies of our military and civilian employees in the Department of Defense and other agencies of the Federal Government.^(11,12)

The separate Army and Air Force medical services' innovation headquarters, located in San Antonio, are looking at the possibility of combining their efforts in a cooperative Federal Healthcare Innovation Center (FHIC). The Navy and other federal medical services have been invited to participate. CAPT Zentmyer embraces the idea, including the assignment of a Navy Medical Department officer in San Antonio for this purpose. He feels such an assignment would help ensure direct, timely Navy representation in sharing of ideas and strategies on all federal health-related innovation endeavors.

FHIN members have been active in marketing their joint innovation efforts. A FHIN information booth was available at the last AMSUS annual meeting, and a FHIN meeting was held in conjunction with the American College of Healthcare Executives Congress on Administration in February 1988.

Future Steps in Navy Medicine Innovation

The management philosophies and strategies required to support innovation have accumulative benefits that permeate an organization and offer a competitive advantage where that is important. There is also ample evidence that sustained, meaningful innovation activities don't just happen. They are the result of managed, orchestrated efforts.⁽¹³⁻¹⁵⁾

Within Navy medicine and the FMS's community, the structure for innovation is in place; the top leadership is committed. It is now in the hands of our activity commanding officers, officers in charge and their immediate staff. It is they who must foster innovative input and operations. An element of risk is involved for the leadership, but this must be accepted if innovation is going to work.

The benefits of innovation are many. For those of us in Navy medicine these benefits include keeping our best people and being able to continue the opportunity to provide services to all our beneficiaries. We must move now to make innovation management in Navy medicine a reality.

Your Opportunity to Participate

The references used in this article offer good background information on the concept of innovation and innovation management. In addition, the authors would be pleased to discuss this vital area of Navy medicine with any interested party. If you would like to communicate with the Navy Medical Department's Innovation Manager he can be contacted at the Naval Medical Command (NAVMEDCOM-32), Washington, DC 20372-5120, or by telephone at Autovon 294-0222, Commercial (202) 653-0222.

An interim electronic bulletin board at the Naval Medical Command Northeast Region, sponsoring command for initial implementation of this endeavor, is on-line for any individual who desires to convey innovative applications or ideas. Interested parties can access this file via modem at commercial (312) 688-4289. Input can also be communicated by way of telefax through Autovon 792-3905. All personnel, regardless of status or seniority, are encouraged to share ideas and successful strategies to foster innovation.

References

1. Shaw DR: Deputy Under Secretary of the Navy (Policy). Speech given at the federal luncheon, American Academy of Medical Administrators' Annual Convocation, Las Vegas, NV, 13 Nov 1987, p 8.
2. Zimble JA: Chief of Naval Operations (CNO) Message R 011619Z June 1988, Washington, DC.
3. Commander, Naval Medical Command: *Grand Rounds With the Surgeon General: Innovation in the Medical Department*. Videotape 804242DN, 1988. Source: Biomedical Communications Center, Naval School of Health Sciences (ATTN: Rose Prakas), Bethesda, MD 20814-5033.
4. Zentmyer RK: Personal communications, Jan 1988.
5. Lambert WJ Jr: Innovation—theoretical buzzword or recipe for survival: The healthcare services perspective. Paper presented before the Panel on Innovation within the Federal Healthcare Services, American Academy of Medical Administrators' Annual Convocation, Orlando, FL, 7 Oct 1988.
6. Kamm JB: *An Integrative Approach to Managing Innovation*. Lexington, Lexington Books, 1987, p 5.
7. Kanter RM: *The Change Masters: Innovation for Productivity in the American Corporation*. New York, Simon & Schuster, 1983, p 20.
8. Ibid, p 21.
9. Peters TJ, Waterman RH Jr: *In Search of Excellence: Lessons From America's Best-Run Companies*. New York, Harper & Row, 1982. This is the source from which the "excellence" concept in management is derived.
10. Walter M: *Deming Management Method*. New York, Donald Mead & Co, 1986. Dr. W. Edwards Deming is internationally known for his management theories which have lead to success in achieving quality control, management efficiency, and high productivity.
11. Department of Defense (DOD): *1987 Annual Report of the Deputy Assistant Secretary of Defense (Installations)*. Washington, DC, DOD, 1987. Highlights the DOD's Excellence Installations—The Foundation of Defense Program.
12. Veterans Administration (now the Department of Veterans Affairs): *VA Pilot Program on Management Efficiency*. Washington, DC, Veterans Administration, 1987.
13. Drucker PF: *Innovation and Entrepreneurship*. New York, Harper & Row, 1985.
14. Peters TJ: *Thriving on Chaos: A Handbook for a Management Revolution*. New York, Alfred A Knopf, 1987.
15. Odiorne GS: *The Change Resisters*. Englewood Cliffs, NJ, Prentice-Hall, 1981. □

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The Challenge of Change

COL Theodore W. Oatley, USAF, MSC

In this decade we have experienced more change in national health care delivery than in any comparable period. Federal health care, paralleling the domestic industry, has been witness to and affected by the same phenomena. This reshaping of the health care process has been driven by many factors, some of which have been more visible than others. Rising health care costs, new standards of care, technological advances, quality assurance, supply and demand, and patient expectations are but some of the forces propelling this change. Together, these and other components have caused a transformation in health care management that has been unprecedented. This rapidly changing environment has introduced to health care managers new and exciting challenges and opportunities. The new health care environment creates unique opportunities to apply innovative and creative solutions to present and future challenges.

The Challenge

The federal health care sector, and in particular, military health care, is facing unprecedented demands to pro-

vide responsive, quality health care to an increasingly large beneficiary population. These demands must be met in a cost-efficient manner, as budgetary and resource limitations continue to be mandated.

Aging facilities must be maintained and altered to meet quality standards even as medical construction dollars not only become limited, but are challenged by increasing costs for new construction. At the same time, we are faced with the continuing requirement of meeting compulsory standards of health care as expensive medical technological advances become the norm.

There are other demands resulting from this changing health care delivery process which pose new problems. Access to health care is becoming more complex as eligible patient population numbers grow at a rate surpassing current capabilities and capacities. With the introduction of the diagnostic-related groups now the basis for future resource allocations and compliance, new and revolutionary managerial processes will become necessary.

With certain health professional specialty shortages, alternatives must

be explored to ensure prompt, appropriate medical care. The national nurse shortage has had a direct effect upon federal health care. Rising CHAMPUS costs continue to escalate, and the shift from inpatient case management to an outpatient setting places new demands on facility configuration and operational protocols. The list goes on.

Many of these problems have been solved with the implementation of new, creative programs to offset the impact of change. To combat escalating CHAMPUS costs, a CHAMPUS Reform Initiative was begun, as well as the Healthcare Finder and Partnership Programs. Legislation for Department of Defense/Veterans Administration sharing and joint venture opportunities have resulted in improved access to care and cost expenditure advantages.

However, there is much more to be done. As health care executives in the field are given more responsibility and authority for managing health care locally, tremendous opportunities will surface. These opportunities (or challenges) will become targets for the innovative and creative mind.

Signing the Federal Healthcare Innovation Proclamation Statement are (left to right): LTG Frank F. Ledford, Jr., MC, Army Surgeon General; RADM H. James T. Sears, MC, Commander, Naval Medical Command, representing Navy Surgeon General VADM James A. Zimble, MC; LTG Monte B. Miller, MC, Air Force Surgeon General; Surgeon General C. Everett Koop; and Dr. John Gronvall, Chief Medical Director, Veterans Administration.

Increased resources in the form of money, manpower, and facilities is not likely to be an option to enjoy. Those who possess the innovative spirit to try to "find a better way" or a new approach to problem solving, should not be deterred. They should be encouraged and supported in their quest to meet *new* challenges with *new* methods.

A Cooperative Approach

The Air Force Medical Service (AFMS) created a Center for Healthcare Innovation (CHI) to develop, evaluate, and encourage creative solutions to what the Air Force faces today and tomorrow. CHI, through several programs, has stimulated innovative health care management throughout AFMS. Resources, in the form of *seed money* to support innovative initiatives have been made available. *Innovator's catalogs* have been published to crossfeed over 1,000 successful innovative applications that have been cost-effective and patient-oriented. A *model facility* serving as a pilot site to test new technologies and apply innovative and creative methodologies is in place. Finally, *Project Excise*, a program for divestiture from programs, policies, and services that have reached a point of diminishing return or no longer serve the purpose for which they were designed has been launched.

These and other programs have proven to be successful for AFMS, and they have complemented and supported other initiatives designed to improve management efficiencies and contain costs. Most importantly, and of great significance, has been the joining of AFMS with other federal health care agencies together to cooperatively tackle common problems.

Early in the evolution of CHI, it became evident that a great potential existed, should all federal health care

agencies muster their creative and innovative initiatives together toward resolving common challenges and improving patient care programs. Subsequently, an invitation was extended to the Army, Navy, Veterans Administration, and Public Health Service to join with the Air Force in participating in a cooperative effort toward bringing active creativity and innovation to all federal agencies.

Each agency responded enthusiastically. The Army's Health Services Command appointed LTC Ken Andrews and MAJ George Masi from their office of Strategic Planning and Innovation. VADM James Zimble, Navy Surgeon General, has identified CAPT Robert Zentmyer and LT David Krieger to spearhead his program. Walter Besecker, director of Strategic Management, and Al Pate, associate administrator of Hines VAMC, are the Veterans Administration representatives. CDR (Dr.) Stephen Permison and CDR (Dr.) Phillip Smith of the Public Health Service were Dr. C. Everett Koop's nominations.

Together, this core cadre and other interested participants have formed the Federal Healthcare Innovation Network (FHIN). On 31 Oct 1988 the Surgeons General of the three military services, the Public Health Service, and the Chief Medical Director of the Veterans Administration formally signed a Proclamation Statement solidifying their collective commitment to FHIN. This new coalition provides the mechanism to facilitate a working relationship that will foster innovation and enhance the provision of high quality and efficient health care services throughout the federal sector.

With the formation of FHIN, an opportunity exists to take on challenges collectively and to work with a common purpose for improved health

care services within all federal agencies. The Delaware Valley Health Services System (DVHSS) has already invited FHIN to participate in their endeavor to create a "model" Federal Health Care Delivery System. It is anticipated that this tri-service cooperative model will serve as an innovative springboard for new management concepts and medical technologies.

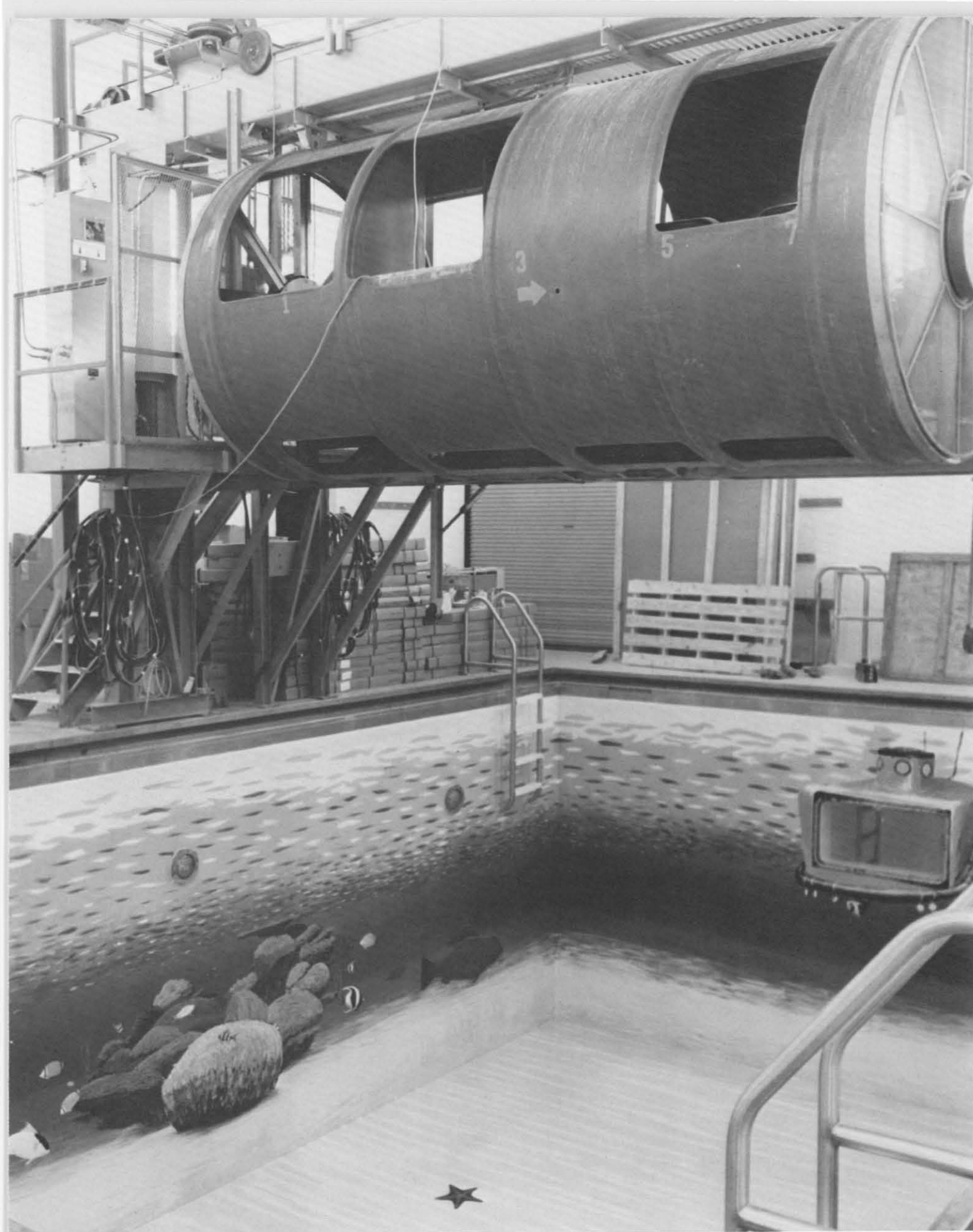
FHIN plans to sponsor several projects in DVHSS such as an Automated Health Care Finder Program which will use interactive video technology to increase patient accessibility to federal medical facilities in the Delaware Valley area. Additional projects include the "bundling" and leveraging of tri-service CHAMPUS and Supplemental Care referrals to the civilian health care sector. This initiative will combine the attributes of the CHAMPUS Reform Initiative, Utilization Management, and other managed health care programs to reduce costs, increase the use of the Direct Care System, and improve the quality of services provided to our collective beneficiaries. Further, FHIN is exploring the opportunities for technological transfers such as teleradiology and voice activated transcribing.

Conclusion

For every new challenge there is a new opportunity, and as our changing health care environment emerges, new initiatives will be born. Traditional solutions to problems that worked in the past may not be effective today, spawning opportunities to capitalize on creative and innovative alternatives.

Federal health care agencies can, both independently and cooperatively, benefit from the creative and innovative minds of their people. This can best be accomplished by a demonstrated commitment to encourage and support innovative alternatives rising from all levels of the organization. □

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Universal Underwater Escape Trainer 9D5 (helo dunker)

Nonaircrew Frequent Flier Training

LCDR Terrance L. Rickey, MSC, USN

Water survival training is not usually associated with naval hospitals, but at Naval Hospital, Cherry Point, NC, such training is conducted by the Aviation Physiology/Water Survival Training Department. The department is staffed by nine hospital corpsmen (NEC 8409), four Navy divers, two aircrew survival equipmentmen, four

contract maintenance employees, and two aviation physiologists. Traditionally, this training has been geared toward aviators and other aircrewmen, but lately the CNO has expanded the scope of water survival training to include frequent fliers.

Frequent fliers are nonaircrew personnel, Navy or Marine Corps, who frequently fly on government aircraft

(other than ejection seat or oxygen equipped). This training is a prerequisite for nonaircrew personnel, and they must participate in underwater egress training in device 9D5 Universal Underwater Escape Trainer (helo dunker). In the Marine Corps this includes troops who would embark in a helicopter from ship to shore or those who would fly during shipboard

Student strapping in.



operations. Nonaircrew Frequent Flier Training is designed to familiarize, not to qualify the individual as an aircrewman.

In order to participate the student must perform a few prerequisite swim skills as established by the Chief of Naval Operations:

- Drownproofing (floating face down in the pool while rising to breathe at a normal breathing cycle).
- Swimming on the surface.
- Treading water, swimming, and drownproofing.
- Manual and oral inflation of the LPP-1 (flotation device used by Navy-Marine Corps).
- Fifteen-yard underwater swim in boots and "cammies."

When these five steps and a classroom orientation on safety and operational procedures are completed, the student is ready for the helo dunker. This device simulates, as closely as possible, an aircraft ditching at sea. Although the actual ditching is usually more violent and less controlled, the trainer does a commendable job. The helo dunker enters the water and rolls over to simulate the most likely scenario of an inverted helicopter. Statistics indicate that in helicopter ditchings at sea the helicopter almost always rolls inverted.

In an actual helicopter crash (H-46), one crewmember had this to say about his survival experience: "As water hit me in the face, I thought I was in the helo dunker and I began to run through an egress drill. The interior became dark; I repeated the instructor's words 'Proceed quickly but calmly.' I pulled the escape handle twice but with no effect. I looked at the door to assure that I had the proper handle. I discovered I was pulling it the wrong way. I pulled correctly and the door came free. I continued the escape process automatically, still thinking I was in dunker training. I forgot to dis-

connect my radio cords which caused my head to be pulled down, I reached back to disconnect the helmet. I thought the instructor was going to make me do it over again. I pulled the right toggle on my life preserver but could not locate the left one. I finally located the left toggle as I reached the surface. Reality returned when I surfaced and was hit by a wave and went under. I was rescued by another helicopter." In this case as well as others the survivors have had great praise for the helo dunker for the quality of the simulation. The primary goal is to make the procedures of the survival episode come naturally.

Some of the participants, due to a lack of swimming skills, aren't able to pass the preliminary process and have to drop out. Hopefully, they will try again in the future. We are not looking for Olympic swimmers, but in order to complete the training evolution safely, a fairly good swimmer is required. While participating in the final phase, which is a ride in the helo dunker, the student is strapped in. The trainer has six seats aft and two pilot seats up front; the pilot seats are not required for the NAFFT class. Each student participates in four training evolutions:

- The *first* simulates a ditching in which all exits are open and the student is allowed to escape from any exit.
- The *second* assumes some exits are jammed by a ditching and requires an exit from the main cabin door.
- The *third* is performed blindfolded to simulate darkness and any exit may be used.
- The *fourth* and final cycle requires the student to escape blindfolded from the main cabin door.

After each training cycle the divers evaluate the procedures used by each student and relay any breaks in procedures to the communication diver

standing by at poolside. Hopefully, the students will learn from their mistakes and, by the time of their last training evolution, will have mastered all required procedures.

The entire evolution is extremely safe. Two qualified Navy divers using surface supplied air are constantly alert for any emergency and are always present underwater. Communication with the divers is accomplished by a diver at poolside. A standby diver in full SCUBA gear is also at poolside



ready for any emergency. If all this is not enough, two qualified water survival personnel (usually HM's NEC 8409 Aviation Physiology Technicians) are equipped with ring buoys and finally, if all else fails, an emergency retract feature of the dunker can bring the entire device out of the water in seconds.

The reception to this training has been gratifying. At Marine Corps Air Station, Cherry Point, hundreds of students have already been trained.

The goal at the Aviation Physiology Training Department, Naval Hospital, Cherry Point is to provide realistic training geared toward the needs of the fleet. Lives can be saved by allaying the fears of those who participate, and heightened awareness can benefit even those who aren't able to complete the training. □

When this article was written LCDR Rickey was assigned to Naval Hospital, MCAS, Cherry Point, NC 28532.

Navy Family Services and the *Stark* Incident

Anton F. Kootte

Recent events in the Middle East and the continued naval involvement in the Persian Gulf recall the tragic events of 17 May 1987 when USS *Stark* (FFG-47) was attacked. Boards of inquiry and newspaper accounts have told us of the military mechanical efficiency, deficiency, and preparedness of *Stark* and the other vessels involved in its rescue. But what about the human side. Were naval medical and social services up to the task?

The Mayport Navy Family Service Center (FSC) played a key role in providing and coordinating services to the many affected families. FSC policy and Mayport's implementation of that policy served to create an agency and an interagency environment that made possible the rapid, efficient, and scientifically sound response to an otherwise largely unpredicted and unprepared for event.

The overall response to the incident, at a local level, was handled through the offices of the commanding officer, CAPT John T. Mitchell, of the Mayport Naval Station and Destroyer Squadron Eight, to which *Stark* was assigned. They first received official notification of the attack at 1800 that evening.

CAPT Mitchell and representatives of Desron Eight met with several key department heads and implemented the appropriate directive. Casualty Assistance Call Officers (CACO's) were assigned, and the SPRINT team (Special Psychiatric Intervention Team) was summoned. Families started to gather at the homes of their ombudsmen. By 2300 FSC was reopened and remained open for the next week, 24 hours a day.

A prayer vigil was established at the chapel, but by Monday morning the sheer numbers of people awaiting notification of their loved one's status exceeded the capacity of the chapel, and so they moved to the Community Center. Its large hall was equipped with cots, blankets, toys, and food. The FSC and chaplains established a watch at the Community Center with the intention of continuing throughout the week or as long as necessary.

The staff of FSC supported families as they waited for news of their loved ones, and counseled and consoled the bereaved. Ombudsmen and volunteers took an active frontline role in serving, comforting, and caring for the assembled families. The emotional impact of the attack on *Stark* extended beyond the families of crewmembers.

Other naval families, particularly those families whose men were aboard other ships in the Persian Gulf, were also strongly affected. Consequently, on the positive side, there was a great outpouring of community, of charity, and compassion. There was no shortage of volunteers. But then the long hours and emotional strain made some workers victims of burnout. Fortunately, burnout manifests itself in essentially the same ways as other emotional crises and responds to the same therapeutic procedures.

In addition to providing crisis intervention counseling, FSC also served as a command center and facilitated the coordination of the many naval and civilian organizations which responded to the emotional, social, and psychological needs of the naval community. Mayport's FSC is centrally located such that it served as a natural meeting ground. It is at the center of a circle that can be drawn from the Administration Building to the Medical Clinic to the Chapel and then to Navy Relief, and the Red Cross is housed within the FSC Building.

Mayport FSC staff members were prepared to fill this role because the major policies guiding the functioning of FSC's require precisely the qualities



Damage to USS Stark following Exocet missile attack.

needed in such a crisis. FSC's have three main functions or service domains: Information and Referral (I&R), Short-Term Non-Medical Counseling (STNMC), and Prevention (see OPNAV 1754). The additional prohibition not to duplicate services mandated that FSC quickly establish an Information and Referral network. This required FSC personnel to establish relationships between the agency and other agencies. To accomplish this, FSC Mayport established a policy that required all counseling staff to spend a certain amount of time in outreach activities. Through this process FSC established relationships with various mental health, family service, and social service agencies in the community.

FSC's civilian staff also needed to

understand the roles and functions of various naval organizations which have an impact on Navy families, such as Navy Relief, Ombudsmen, the Counseling and Assistance Center (CAAC), medical services, administration, the chain of command, and the military justice system. Toward this end, FSC Mayport held orientation briefings for specific organizations or groups. Thus, there were meetings with all the local commanding officers, chaplains, and master chiefs.

These meetings served to educate the naval community about FSC services and educated FSC staff about the Navy. The formation of the FSC Advisory Board also served this end, as its members included representatives of all naval administrative and human

service organizations as well as representatives of many civilian agencies. The relationships and understandings established in these and other meetings were invaluable during the *Stark* crisis.

FSC's second major program area, Short-Term Non-Medical Counseling, is directly linked to the Information and Referral process and requires that all staff be trained in crisis intervention and brief therapy techniques. Once a client's immediate crisis state is assessed and stabilized, clients can be referred to outside providers who can offer longer term treatment under the auspices of CHAMPUS.

Thus, not only were FSC staff prepared to deal with a crisis, they were also used to very short therapeutic relationships and accepted the need to

refer clients to other providers. Their training and experience prepared FSC staff to deal with the emotional reactions on the part of family and friends to the shock and loss of their loved ones.

The designation, "non-medical," is to distinguish FSC's from mental health clinics. Psychiatric disorders are considered within the realm of the medical clinic. Of course, clients with psychiatric crises of one sort or another do present themselves to FSC's. Staff should, therefore, be prepared for such clients and know when and how to refer properly and, if necessary, accompany them to a medical facility. Thus, FSC easily established a close working relationship with the medical personnel of the SPRINT team.

FSC's third program objective, Prevention, is closely linked with the first two programs. "Primary" prevention eliminates a disease or problem by stopping its occurrence, as vaccination prevents later infection. Secondary prevention entails early detection and treatment, for example, high blood pressure screening. Tertiary prevention refers to rehabilitation aimed at reducing the disability and cost of disease.

Prevention, particularly primary prevention, aside from its intrinsic desirability, is also thought to be a more cost-effective use of manpower and money. In human service agencies, prevention generally manifests as education and classes lend themselves to groups.

FSC Mayport offered various groups and classes as a means toward both primary and secondary prevention. Thus, they were prepared to work with groups of people, as they needed to, during and following the *Stark* crisis.

During the year and a half that FSC Mayport had operated prior to the *Stark* Incident, the most popular and widely attended programs were "Stress Management" and "Crisis Intervention." The knowledge and skills these programs had disseminated throughout the naval community undoubtedly

were of value during the crisis. "Crisis Intervention" had been targeted toward those personnel who would most likely be the first contact a person in need might turn to. Thus, training was provided to the ombudsmen, master chiefs, and DAPA's.

A major part of FSC Mayport's prevention activities is its "Deployment Program." Each vessel that desired to participate was given an FSC staff member as ship's sponsor. The sponsor would work with the command in planning an individualized deployment program.

This program generally consisted of meetings and presentations, giving advice on how to manage stress, dealing with finances, coping with family problems, staying in touch throughout the deployment, and so forth. If desired, the program could include a "Return and Reunion" portion which brought FSC staff and other personnel to the ship to offer programs and services to the crew on their return voyage.

These programs had been conceptualized as primary prevention, but in the case of *Stark* (who did have a "Return and Reunion" team) FSC's activities were clearly secondary prevention. The trauma had already occurred. The grief-producing loss could no longer be avoided. Wives clubs, already in place, functioned as wives "groups" and in the case of *Stark* subdivided into a widows and a survivors group. These groups quickly functioned wholly on their own.

Exposure to violent trauma of the intensity of the *Stark* tragedy often results in psychological distress, anxiety, depression, and other symptoms, known as post-traumatic stress disorder (PTSD). In keeping with the principles of good combat psychiatric practice (Glass, 1969; Belenky & Jones, 1987), *Stark's* casualties were treated by the SPRINT team "at the front;" with rest, emotional ventilation, and supportive listening, sleep, sparing use of tranquilizers, and the expectation that the crew would return to duty. And return to duty they did; there were few acute reactions to the

event. Yet the men had not discussed their experiences, not even with each other, a month after the event. Some were abusing alcohol to sleep without dreams. In time some would show the classic signs of PTSD, and they would receive appropriate treatment.

FSC Mayport secured the services of the local Vietnam Vet Center, experts in PTSD treatment, for *Stark* personnel. In addition, an educational program aimed at "preventing" PTSD was offered to the officers and men of *Stark*. These programs openly discussed the possible psychological consequences of exposure to trauma of the intensity of the *Stark* tragedy.

Were Navy medicine and social services prepared to meet the task of managing the shock, grief, and post-traumatic sequelae upon the men and families of *Stark*? Yes, they were. CACO's, ombudsmen, medical and administrative personnel—the whole community—acted together to meet the crisis. Whether there would be enough trained personnel available to meet a similar crisis of greater proportions is another question. One can always call for more training, and some Naval Stations and Family Service Centers may not be as well prepared as Mayport was, but the organizations and policies are in place to meet this type of disaster.

Bibliography

Glass AJ: Introduction, in Bourne PG (ed): *The Psychology and Physiology of Stress: With Reference to Special Studies of the Viet Nam War*. New York, Academic Press, 1969, pp xiv-xxx.

Belenky G, Jones FD: Combat psychiatry—an evolving field, in Belenky G (ed): *Contemporary Studies in Combat Psychiatry*. New York, Greenwood Press, 1987. □

Mr. Koote was the stress management counselor at the Mayport Navy Family Service Center at the time of the *Stark* Incident. He is now a medical social worker at Mayo Clinic, Jacksonville, FL 32224.

The Hippocratic Oath's Secrecy Clause: A View From the Courts

CAPT Vernon J. Moore, MC, USNR-R

Whatever, in connection with my professional practice or not in connection with it, I see or hear, in the life of men, which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret.

—from the Oath of Hippocrates, 5th Century B.C.

Exceptions to the Rule

"Physician-patient confidentiality" expresses a long-standing ethical principle well known to both military and civilian physicians. American society values this principle, although recognizing through its law that the patient's expectation of privacy is not absolute. Navy regulation, for example, states:

The medical officer or dental officer shall inform, in writing the commanding officer and the person concerned whenever an entry is made in the latter's medical record which indicates that a disease or injury may be attributable to misconduct, or indicating the use by such person of intoxicants, marijuana, narcotic substances or other controlled substances as defined in these regulations to a degree presumed to disqualify him physically, mentally, or morally for performance of duty.(1)

Similarly, physicians involved in court martial proceedings are familiar with the evidentiary rule which provides that "information not otherwise privileged does not become privileged on the basis that it was acquired by a medical officer or civilian physician in a professional capacity."(2)

Legislatures and courts have created other exceptions such as the reporting requirements triggered in situations of suspected child abuse or the treatment of gunshot wounds. In the *Tarasoff*(3) case, of eponymous proportions within both the legal and psychiatric professions, the California Supreme Court held that where a patient has confided an intent to murder an identified third party, the therapist has a duty to frustrate that design, even by warning the target. The court in reaching its conclusion cited a pertinent position statement of the American Medical Association:

A physician may not reveal the confidence entrusted to him in the course of medical attendance . . . unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.(4)

An Emerging Area of Tort Liability

Civilian physicians today, including the over 11,000 in the reserves, increasingly are aware of an emerging issue of liability: the allegation of breach of confidentiality. This article examines the question for the benefit of the military physician. Whether a career officer, or one contemplating

"Information not otherwise privileged does not become privileged on the basis that it was acquired by a medical officer"

release from active duty in the near future, or involved in outservice training or "moonlighting," the lesson to remember is that to breach his or her patient's confidences, absent a legal justification, "is tortious conduct which may be basis for an action in damages."(5)

Court reporters published periodically over the years document that lawsuit frequency in this area is on the rise. The table below reflects this.(6) Perhaps physician desensitization leads to this pitfall. In an age of omnipresent peer review, 3rd party payer requests and external accrediting organization surveys, the patient's medical record often seems an open book.

Decade	Number of Cases
1946-1956	0
1956-1966	7
1966-1976	8
1976-1986	25

Recent Decisional Law

For purposes of background, recall that four separate sources of law may apply when a court considers a "case or controversy."

- The Constitution (federal or state)
- Statutory law, enacted by the legislature
- Decisional case law developed by the judiciary
- Administrative regulations

Courts in various states in interpreting and applying the relevant law may differ in their conclusions. Thus, for example, on the issue of what constitutes an informed consent, some states have adopted a standard of what a reasonable patient would want to know, others of what a prudent physician would communicate under similar circumstances. With that caveat in mind the cases to follow illustrate these points:

- Part of the physician-patient contract is the warranty of silence.
- A breach of contract action against the physician is recognized.
- Courts like legislatures can define public policy and have addressed confidentiality in that context.
- Unless a patient authorizes release of information or waives same by an affirmative action (e.g., filing a lawsuit) or there exists an exception, a physician breaches confidentiality when disclosure is made to a 3rd party, including the physician's professional liability insurance carrier.

Our review begins and will conclude by reference to *Hammonds*,⁽⁷⁾ a case heard in a federal court in Ohio because the parties were residents of different states. As fallout to an action originally against a hospital, plaintiff *Hammonds* next directed his suit against the hospital's insurer, alleging that the insurer had induced the plaintiff's treating physician to divulge confidential information. Ruling only on a procedural question, the court in denying the insurer's motion to dismiss the action, stated in the context of Ohio law:

Action against doctors for releasing information gained while treating patients are rare in American jurisprudence, which in itself, is something of a tribute to the medical profession. When recovery has been allowed, it has been grounded upon either of two factors: (1) the testimonial privilege statute which precludes disclosure in court of information gained through the physician-patient relationship, and (2) a requirement in the state medical licensing statute which precludes the disclosure of such confidential information.⁽⁸⁾

Several months later the same court in denying the insurer's request for reconsideration further explained:

Any time a doctor undertakes the treatment of a patient, and the consensual relationship of physician and patient is established, two jural obligations (of significance here) are simultaneously assumed by the doctor. Doctor and patient enter into a simple contract, the patient hoping that he will be cured and the doctor optimistically assuming that he will be compensated. As an implied condition of that contract, this court is of the opinion that the doctor warrants that any confidential information gained through the relationship will not be released without the patient's permission. Almost every member of the public is aware of the promise of discretion contained in the Hippocratic Oath, and every patient has a right to rely upon this warranty of silence. The promise of secrecy is as

much an express warranty as the advertisement of a commercial entrepreneur. Consequently, when a doctor breaches his duty of secrecy, he is in violation of part of his obligations under the contract.⁽⁹⁾

The coupling of the patient's identity to his medical history or the procedure performed is critical to the idea of breaching confidentiality.⁽¹⁰⁾ The presentation of patient histories, growth charts, X-ray films, etc. at conferences

The important lesson to remember is that to breach his or her patient's confidences, absent a legal justification, "is tortious conduct which may be the basis for an action in damages."

promotes medical education but under optimal conditions no breach occurs because the patient's identity is appropriately obscured. In *Geisberger*⁽¹¹⁾ an Illinois appellate court confronted the question of whether disclosure to the police of only the patient's name by his treating physician's employee breached the standard. In affirming the trial court's dismissal of the complaint, the appellate court stated:

Unlike the attorney client relationship, the common law [judge made] does not recognize a privilege for the communication between a doctor and patient. Illinois has statutorily protected from disclosure certain information obtained by a physician in his professional relationship with a patient. Whether a name is protected, therefore, depends entirely on the extent of the privilege under that paragraph.⁽¹²⁾

* * *

For all practical purposes the breach of a confidential relationship and the breach of contract are probably co-extensive. In other words, those disclosures which violate the statutory privilege also define what is actionable under a contract theory. The cases that have recognized a contract theory as a cause of action make it clear that the action lies for disclosure of 'personal' information, e.g., information relating to the patient's mental and physical condition or physician's diagnosis or treatment. The prohibition of disclosures contained in the Illinois statute, the Hippocratic Oath, and the Canon of Medical Ethics support this conclusion.⁽¹³⁾

Apropos the court's comment of the absence of a "common law privilege" regarding communications between patient and physician, this simply meant that a court could compel a physician to disclose information.⁽¹⁴⁾

The discussion and further elaboration of this issue continued in *Petrillo*,⁽¹⁵⁾ a products liability case. Therein, an Illinois appellate court enunciated "public policy" as prohibiting extra-judicial conversations between the defendant and the plaintiff's treating physicians:

Public policy is found in a State's constitution and statutes and where these are silent, in the decisions of the judiciary. An act can be against

public policy even though it is not specifically prohibited by a State's statutes or constitution for a finding of public policy can often be inferred from these sources.(16)

* * *

In the case at bar we believe that modern public policy strongly favors the confidential and fiducial relationship existing between a patient and his physician. We further believe that this public policy arises from the fact that society possesses an established and beneficial interest in the sanctity of the physician-patient relationship. We find this public policy to be reflected in at least two separate indicia: (1) the promulgated code of ethics adopted by the medical profession and upon which the public relies to be faithfully executed so as to protect the confidential relationship existing between a patient and his physician and (2) the fiduciary relationship recognized by courts in Illinois as well as courts throughout the United States, which exists between a patient and his treating physician. Because public policy strongly favors both the confidential and fiduciary nature of the physician-patient relationship, it is axiomatic that conduct which threatens the sanctity of that relationship runs afoul of public policy.(17)

In the court's view the code of ethics adopted by the medical profession had three separate prongs:

- The Hippocratic Oath
- The American Medical Association's "Principles of Medical Ethics"
- The "Current Opinions of the Judicial Council of the American Medical Association" (1984 edition)

"These three prongs underscore the highly confidential nature of the physician-patient relationship and, perhaps more importantly, advertise to the public that a patient can properly expect his physician to protect those medical confidences which are disclosed during the physician-patient relationship."(18)

"Because public policy strongly favor both the confidential and fiduciary nature of the physician-patient relationship, it is axiomatic that conduct which threatens the sanctity of that relationship runs afoul of public policy."

An intriguing problem not confronted by the active duty officer is under what circumstances a physician may discuss his patient with his professional liability insurance carrier. The *Hammonds* case which led off this article touched upon this; a recent New York case confirmed the result. In *Rea*(19) a trial court had ruled that even though the patient's attorney had requested the physician to produce medical records, the physician was not justified in also sending the records to his malpractice insurance carrier in order to trigger the notice provisions of his "claims-

made" policy. Reversing the trial court, the appellate court stated:

We adopt the test established in *Hammonds*: an insurer may persuade a doctor to disclose certain medical secrets of the patient, and a doctor may share such information with the insurer, when the doctor has a reasonable belief that a claim for medical malpractice will be made against him by the patient. The doctor's belief is reasonable only if the (patient) knows or suspects that he is the victim of medical malpractice and has expressed an intent to pursue his legal rights by informing the doctor of his intention to make such a claim or by performing some other affirmative act from which the doctor may reasonably infer such an intention.

* * *

We hold that, where the case involves a precommencement authorization for medical records to the patient's attorney, such authorization justifies the doctor's disclosure of those records to his attorney or carrier.(20)

Conclusion

In 1986 Congress opined in legislative history accompanying the "Health Care Quality Improvement Act" that "any practitioner—even the most skilled and careful—can make an occasional mistake."(22) Litigation involving one type of mistake, breach of confidentiality, has increased over the decade 1976-1986. Recent court decisions from the jurisdictions of Ohio, Illinois, and New York have been reviewed and reflect a trend toward construing secrecy broadly in favor of the patient. The author recommends greater awareness of this issue among members of the military medical community.

References

1. *United States Navy Regulations*, 1111.2, 1973.
2. *Manual For Courts Martial United States*, Military Rules of Evidence 501.d, 1984.
3. *Tarasoff v. Regents of the University of California*, 551 P 2d 334 (CA, 1976).
4. *Principles of Medical Ethics of the American Medical Association*, section 9, 1957).
5. *Hammonds v. Aetna Casualty & Surety Company*, 243 F Supp 793, 802 (ND, OH, 1965).
6. *Decennial Digest(s)*, Physicians & Surgeons, section 15 (9), West Publishing Co.
7. *Hammonds v. Aetna Casualty & Surety Company*, 237 F Supp 96 (ND, OH, 1965).
8. *Id* at 101.
9. See note 5, *supra*, at 801.
10. *State of Indiana v. Jagers*, 506 NE 2d 832 (IN, App 4 Dist, 1987).
11. *Geisberger v. Willuhn*, 390 NE 2d 945 (IL, App 2 Dist, 1987).
12. *Id* at 946.
13. *Id* at 948.
14. *Coralluzo v. Fass*, 435 So 2d 262 (FL, App 3 Dist, 1983).
15. *Petrillo v. Syntex Laboratories*, 499 NE 2d 952 (IL, App 1 Dist, 1986).
16. *Id* at 956.
17. *Id* at 957.
18. *Id* at 957.
19. *Rea v. Pardo*, 507 NYS 2d 361 (Supp, 1986).
20. 522 NYS 2d 393, 397 (AD 4 Dept 1987).
21. Public Law 99-660, 42 USC § 11101 et seq.
22. House Report 99-903 (Committee on Energy and Commerce) p 13, 1986. □

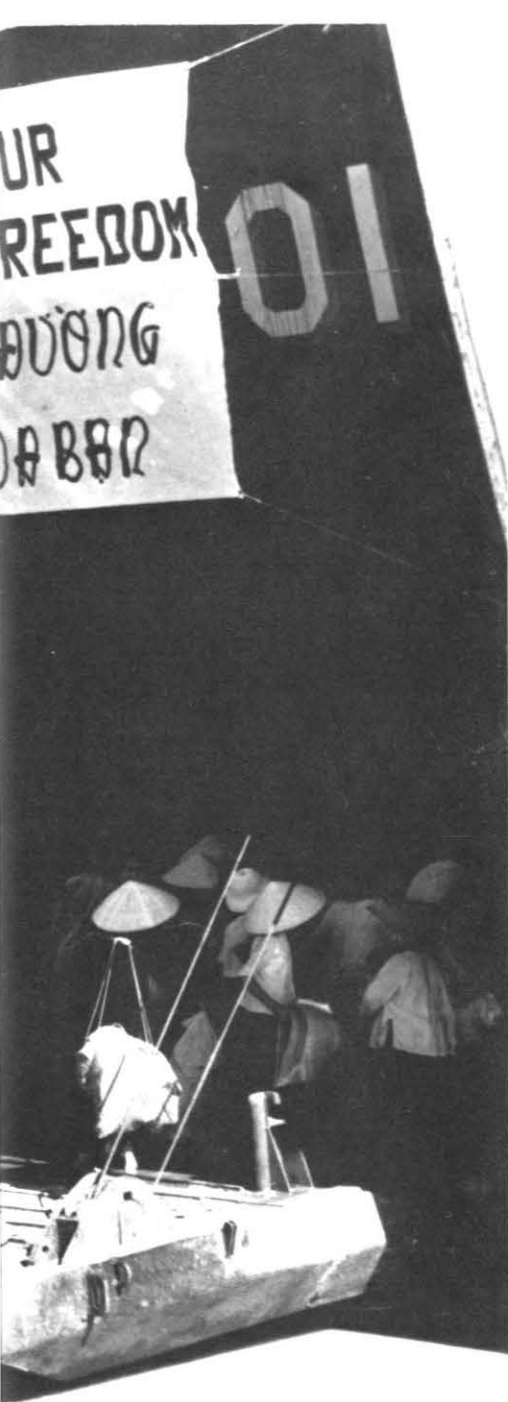
Dr. Moore drills with NR EPMU 1, Det. 113, Naval Reserve Center, Forest Park, IL 60130.

Photos from NAVMEDCOM Archives



Operation Passage to Freedom (17 Aug 1954 to 19 May 1955)

CAPT Julius M. Amberson, MC, USN (Ret.)



Symbols of the great migration to South Vietnam.



Thirty-five years ago and a full decade before the United States became embroiled in the Vietnam War, the French colonial empire in Indochina came to a chaotic end. In May 1954, following their climactic defeat at Dien Bien Phu by the Vietminh, the French hastily began withdrawing from Vietnam. Hundreds of thousands of refugees streamed south to escape the Communists in the north. Many, temporarily marooned in the port city of Haiphong, owed their rescue to the U.S. Navy.

The following article was originally presented as a lecture at the U.S. Naval Medical School in 1955. Dr. Amberson, who died in October after a long, distinguished career (see page 32), was the medical officer in charge of "Operation Passage to Freedom."

Early in August 1954 the Commander of Naval Forces Far East received orders from Washington to mobilize a naval task force for the purpose of evacuating refugees from northern Vietnam to designated places of safety

in southern Vietnam. The Communists under their Vietminh leader, Ho Chi Minh, had just broken the back of French resistance after 7 years of war. Dien Bien Phu was their Waterloo.

By the Geneva agreement there was a "provisional military line of demarcation" at the 17th parallel by which the commanders in chief of the Vietminh forces on the north and the Vietnam forces on the south were placed in charge of civil administration and relief on their respective sides of the line. Provision was also made for a

small area around Haiphong for withdrawal of the French from the interior. All refugees were to congregate also at Haiphong for evacuation.

Naval Task Force 90, commanded by RADM L.S. Sabin, was dispatched to Vietnam to assist the French in the evacuation of both civilian and military personnel as well as all military equipment which might be brought to the beaches and docks at Haiphong. Certainly the French forces deserve outstanding praise and credit for their efforts in this successful evacuation designated as the "Passage to Freedom."

The mission of the Medical Department was set forth succinctly in the medical annex of the operation order for this task force. In effect it said we would maintain sanitary conditions throughout each ship, prevent epidemics in our personnel, and provide humanitarian care and medical attention to the refugees as they came within the orbit of our operations, both ashore and afloat.

The task force began to assemble from various Pacific sectors in the vicinity of Haiphong about 15 Aug 1954. The admiral's flagship, USS *Estes*, arrived in Tonkin Bay on 18 Aug 1954. Many of these ships had too deep a draught to go up the Red River channel to Haiphong, but could be loaded from LST's which were more suitable for embarking personnel from the beaches along the Red River.

The scene seemed peaceful with merchant ships plying toward the Red Delta. Sampans with butterfly sails were yawing and tacking about on an undisturbed course. We dropped our "hook" at 1700 hours. American Military Assistance Group officers from Haiphong came aboard for a conference on evacuation problems. We found it was necessary for us to establish good liaison with the French and Vietnamese in order to give medical assistance where and when indicated and to expedite the delousing of refugees at our embarkation points in the Red Delta.

On 19 Aug 1954 RADM Sabin directed us to go ashore to establish the

necessary medical and sanitary facilities which would be needed for the refugees and, insofar as possible, to establish good liaison with the French and Vietnamese to expedite the mission. Our flagship lay about 2 miles offshore from the mouth of the Red River. We went ashore with a jeep and landed on the Do San Peninsula.

I was accompanied by LT Edward Gleason, MSC, USNR, a public health officer of the Navy. After disembarking on a hard seaplane ramp we made our way toward Haiphong, a distance of 20-25 miles over a hard-surfaced tarmac road, passing many guarded roadblocks. French, African, and Vietnamese troops were manning these stations. The French Foreign Legion was very much in evidence. We passed over a broad plain being planted with rice. Many carabaos were plowing the deep mud and water of rice paddies. These pastoral scenes were soon to stand out in sharp relief against conditions we were about to view in Haiphong and its environs.

As we entered Haiphong we found every available vacant lot, parks, schools, and vacated buildings packed with refugees. We estimated there were about 200,000 at that time. They were living in the most squalid conditions—no sanitary conveniences. The human excreta combined with the presence of enormous numbers of flies were the making of epidemic diseases among these unfortunates. We visited other camps outside the city which had been set up from their meager belongings.

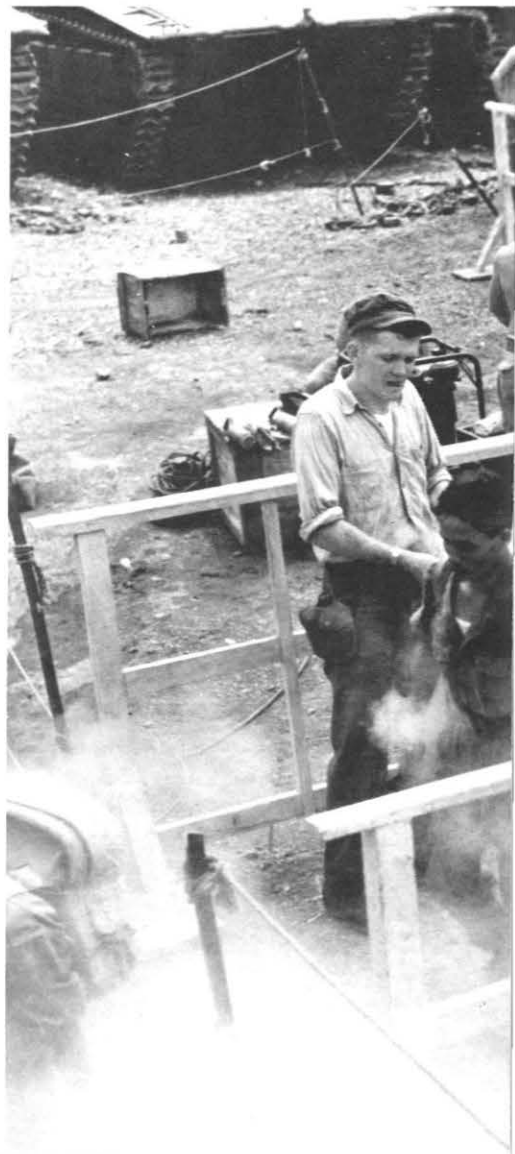
These camps were usually near a pool of rice paddy water. There were no sanitary arrangements. People were sitting under shelters, improvised from rice mats, cloth, or some type of plastic. Tents and shelter facilities were limited. Water was taken directly from the rice paddies and consumed raw. Wormy feces were common and carelessly scattered about. Flies were present in large numbers. The heat was intense. Strong odors permeated the air.

There were many pregnant women as well as many small children and old people. The absence of young men was

obvious. Family groups huddled together and seemed quite destitute.

Meetings were held with various French and Vietnamese officials, including Vietnamese Public Health people of Haiphong regarding assistance the Navy might render in expediting the welfare and evacuation of refugees from the city. LT David Davis, MC, USNR, and LTJG Thomas A. Dooley III, MC, USNR,* served as French and English interpreters during these interchanges of view and expressions of international goodwill. We found the civilian Vietnamese to be very nationalistic and determined to run their own show. However, we indicated that wherever we

*LTJG Dooley went on to write *Deliver Us From Evil*, recounting his experiences in this operation.



might be of service in getting better camps set up, good water supply, and providing additional medical supplies, we would be glad to do so.

Our Military Assistance Group and a representative of the Foreign Aid Administration, Mr. Michael Adler, were primarily effective in bringing in tents and getting two new tent camps set up outside of Haiphong to be used as a staging area for about 12,000-14,000 refugees just prior to embarkation. After these were erected by Legionnaires and French Algerian troops, our Navy medical group took over sanitation of these camps and, under the direction of LT Gleason, we set up units for the filtration and purification of water. At first the natives were slow to accept this clean, clear, chlorinated water but after some days took freely of it. There were saboteurs in

these camps who slashed our large rubber water storage tanks but this was stopped by erecting a barbed wire barrier around each tank and putting Senegalese guards from the Foreign Legion to prevent such incidents.

As soon as the Military Assistance Group, Foreign Aid Administration, and French and Vietnamese Evacuation Committees began moving the refugees from the staging area to our embarkation points along the Red River, we set up DDT dusting stations, manned principally by U.S. Navy corpsmen and beachmaster personnel, through which all refugees passed to have their bodies and personal effects disinfected before embarking on our ships. They passed through our lines at the rate of 1,000 per hour. Mechanical power dusters with 10 outlets were used. Several of these

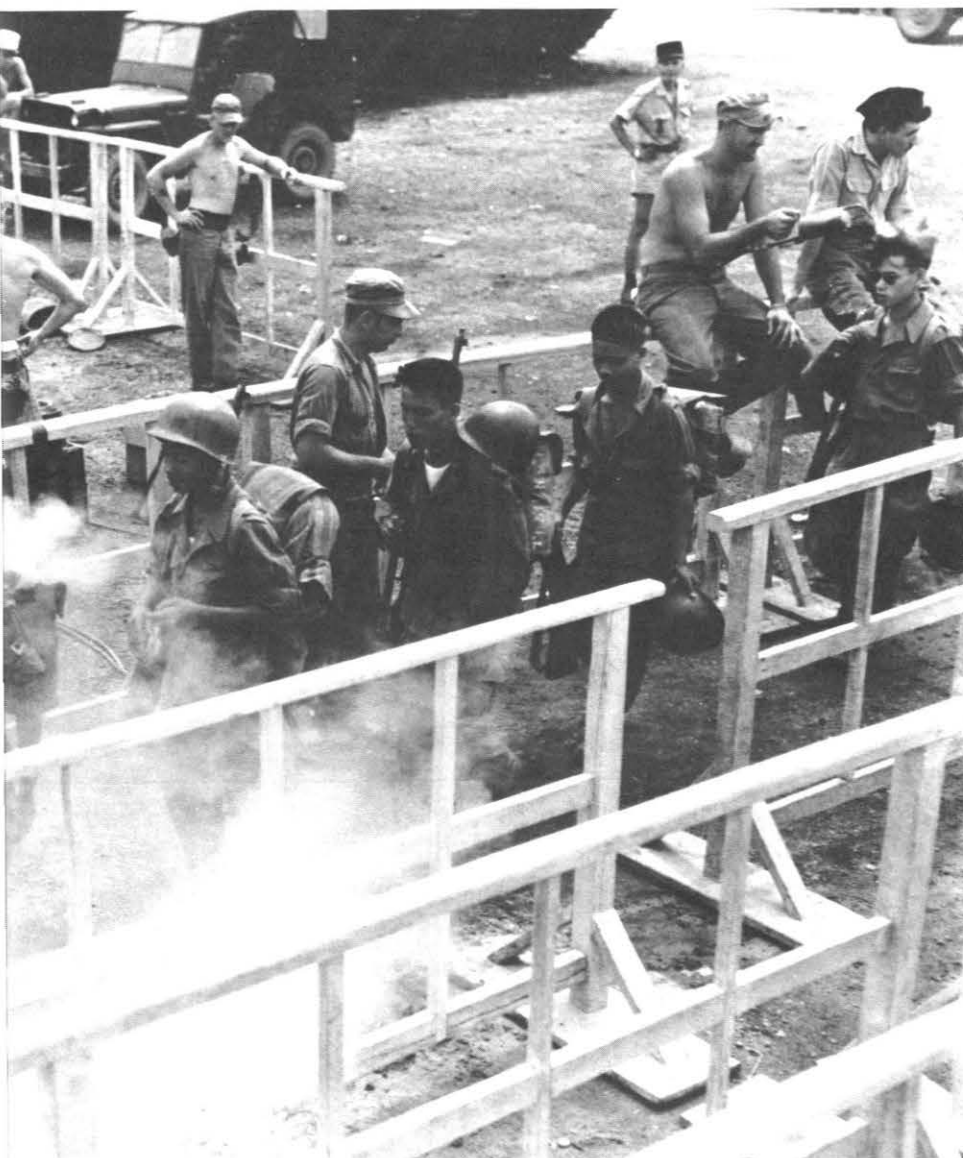
were in operation. The majority of the refugees were Catholic Tonkinese led by their priests. There were other groups as well, particularly Chinese families who had been in Indochina for generations.

In the staging areas and at our embarkation points, medical attention was provided mainly by the Vietnamese Public Health Services of Haiphong. We gave impetus to this service from the start, as none was provided the refugees during their great influx into Haiphong. The Vietnamese Public Health Service immunized all refugees against cholera and smallpox.

There was a lack of medical supplies among the Vietnamese, and these were provided from the American Foreign Aid Organization sources upon our recommendation and selection. It was evident that the peasants from the interior of the country had had little, if any, medical attention all their lives. One could surmise from the total number of medical practitioners in the country that 23 million people could not get adequate medical care from 500 doctors, the majority of whom were concentrated in the larger cities.

One was daily confronted with hordes of people with different eye diseases. Blindness was prevalent in the young as well as the old. Pyogenic infections of the scalp of young children were very common as well as numerous other skin diseases. Dysentery and intestinal parasites were also very common, and one only had to walk through a campsite any morning to see the writhing worms in the fresh stools scattered about.

Malaria was prevalent in all groups, and some were too ill to accept passage at times. Whenever a person was found too ill to be sent to sea, usually the whole family would fall out of line and stay behind as the family ties were very strong, and they sensed that their best chance of survival rested in a fam-



Vietnamese troops are dusted with DDT by Navy preventive medicine personnel before boarding an LST that will take them south.

ily unit. All were poorly clad, wearing only their cotton trousers, top shirts, and a peaked straw sun hat. Nearly all were barefoot and practically all children were half dressed or naked.

Just before embarkation each mother was given a blanket or a sheet for babies in arms. Funds for this were provided by the American Foreign Aid Organization and local Vietnamese social workers, supervised by Mme Vu Thi Ngai, who dispensed the cloth as indicated. Mme Vu Thi Ngai also maintained her own private orphanage in Haiphong which enabled her to rescue many lost or abandoned babies and young children. She gathered about 400-500 around Haiphong. To all these children we gave medical attention. Her orphanage was eventually transferred to Saigon, but her efforts still required much outside support, if these children were to survive.

All refugees were permitted to take as much personal baggage as they could carry on a split bamboo pole loaded at each end and mounted over their shoulders. Usually these personal effects consisted of a rice mat to sleep on, cooking utensils, and rice and fish. Rice constituted most of the weight. However, rice and fish were provided on board ship for each contingent during their passage south. Each ship provided medical care to everyone during their sea journey, which for many was the first in their lives. Motion sickness was common. Their wounds were dressed by our corpsmen and more serious cases like fractures, obstetrics, and fevers were handled by a Navy doctor.

The disposal of the dead at sea posed some questions as to the nationality of the individual, his religion; the desires of the immediate family had to be taken into consideration. It so happened that almost everyone who died en route was Christian and burial at sea was permitted. It was estimated at the start of operations that we might have an average of four births and two deaths on each sea trip. These estimates proved to be fairly accurate. Barrier paper was provided by the Navy in which the remains were

wrapped and the usual Christian burial rites were performed before being committed to the sea.

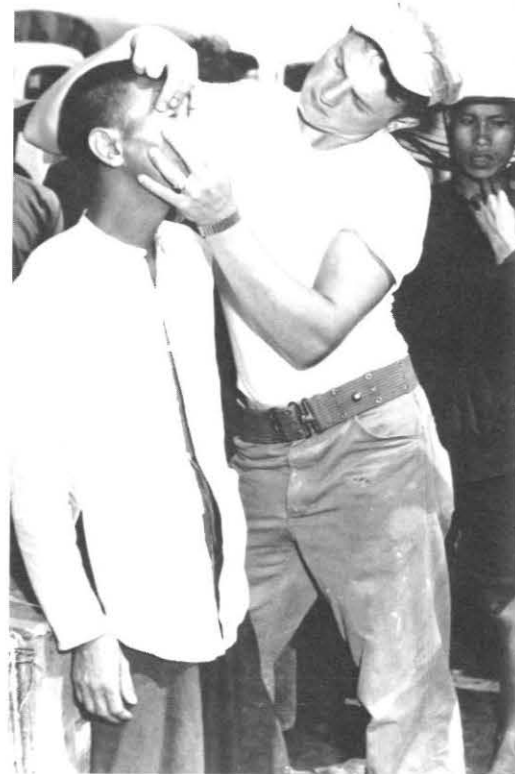
I shall now refer to some phases of our work in connection with the evacuation. We anticipated the need for laboratory controls in our preventive medicine activities associated with our ships and their personnel. This laboratory had to be shore-based in order to serve our ships which plied back and forth between Haiphong and Saigon and points between. We asked the French Naval Commandant, RADM Jean Querville, for space in one of his buildings on the French naval base along the Red River at Haiphong. He quickly and graciously provided running water, electrical service, and an electric refrigerator. We were in business.

LT Richard Kaufman, MSC, and five corpsmen set up and manned departments in bacteriology, entomology, parasitology, and general zoology. This enabled us to collect and process important medical material, make water analyses for all our ships, identify insects of medical importance in the region, and ascertain the kinds of human parasites in this population.

We had two combat cameramen attached to our shore unit for the purpose of making a record of the refugee movement. All scenes shot followed a prepared script to assure complete coverage of every aspect of the refugees' life from the time they were seen approaching Haiphong, arrival in villages and camps, medical care, food and shelter, DDT work and embarkation, and also their sea trip and life en route to destination in southern Indochina.

Between our various operational activities we maintained communication by radio.

The life of the refugees was not without hazard and discomfort even in our improved camps. Typhoons blew down tents; rain and high tides flooded them out on numerous occasions. Tents were struck by lightning, killing or injuring the occupants. We made many medical inspection tours among the people in our camps to administer



to their needs in addition to the Vietnamese first aid arrangements which were set in motion by us.

We combatted much of the adverse Communist propaganda that was prevalent about Americans. Many erroneous ideas were sown: Our DDT was a slow poison;* that we were going to charge \$60 a head for passage to freedom; that we might drown them at sea by opening up our LST bows, or that we might take them away from Indochina forever. Reports of Communist atrocities on refugees were coming in, and we saw some evidence of beatings and bayonet wounds. Also mothers reported the Communists would wrench babies from their arms and run away with them in order to break up families and impede the exit of these people from Communist-won areas. All these hazards and diversions thrown in their path were contrary to

*DDT's adverse and long-lasting impact on the environment was unknown in 1954 but, in fairness, it was the most effective insecticide then available.



Navy corpsmen treat eye infections at the La Pagode refugee camp, Haiphong.

away. However, the refugees continued to come through, and during late October and November 1954 thousands of people escaped from Bin Chu, Phat Dien, and Tani Binh areas of Tonkin.

Many managed to reach the 3-mile continental limit on rafts and small junks where ADM Querville's small naval craft picked them up and brought them up the Red River at night to our embarkation site. The health of these people was poor, as they had endured many months of hard labor under the Communists, rebuilding their railroads. In addition, they had to find their own food where they could, as none was supplied by the masters of North Indochina. Many were found beaten and fractures were common.

By the end of January 1955 about 200,000 refugees had been moved by the U.S. Navy. The refugees were still being moved by sea at the rate of 6,000 per week and by French Air at the rate of 500 per day. Haiphong was by this time a dying city. Nearly all business had ceased and moved out. Of the 100,000 French forces there in August 1954, less than 15,000 now remained. All Vietnamese Public Health people had gone south to Saigon.

By the middle of March 1955 we were able to strike our temporary camps for refugees and house them in the huge abandoned military barracks in the city of Haiphong. Our water purification units were recreated and put aboard our transports for safekeeping. The water supply in Haiphong would suffice for the refugees. We continued to delouse the refugees before embarkation on our ships. Also

we sprayed for fly and mosquito control in the areas where refugees were housed in Haiphong as the insect problem was immense and almost overwhelming.

By this time about 750,000 refugees had been taken out; 250,000 of them in American bottoms. Admiral Sabin's task force expeditiously and with tender care moved these people to safety. The force medical officer, CAPT James Grindell, MC, coordinated the medical activities between the ships of the task force and maintained continuous medical service for the refugees from the embarkation point to the debarkation points in South Indochina. He also instituted preventive medicine measures for the maintenance of health of all our naval personnel manning Task Force 90. Weekly suppressive doses of chloroquine against malaria were taken by everyone, immunization boosters were given, rat and insect control measures were stepped up, and each ship was cleaned after each load of refugees debarked. CDR Sidney Britten, MC, relieved me, and later he was relieved by LTJG Dooley, who remained in charge of medical activities in Haiphong until the Communists moved in on 19 May 1955.

The French pulled out their last forces of 12,000 on 7 May. Their remnant forces were on the Do San Peninsula, the last bit of land at the end of the Red Delta. Subsequent movement would be removal to sea by their Navy.

Epidemics and famine were beginning to occur in Annam and Tonkin. All health and immunization programs had begun to break down in Communist areas. The horsemen of the Apocalypse have taken over where once peace, plenty, and happiness reigned. The U.S. Navy, however, wrote a new chapter in its long and glorious history in defending the weak, rescuing them from slavery and death.

□

the Geneva Accord signed by both the Communists and the French which agreed to let each person have a free choice as to the side on which he wished to live and be allowed to go unmolested to that area.

By 21 Sept 1954, after a month's movement of refugees, the 100,000th refugee passed through our embarkation point. He was an itinerant tobacco salesman with a wife and four children. They were photographed, picked up by one of our helicopters, flown to our flagship, and taken to Saigon that way instead of the usual sea trip on one of the regular transports. This family was feted in Saigon upon arrival and given presents and made to feel that there was a bright future for themselves and all their people who had been rudely uprooted from their ancestral abodes.

By the end of September 1954 fewer refugees were coming in as the Vietminh, or Communists, were controlling their movements. All their sampans were confiscated and other means of transportation were taken

In Memoriam

CAPT Julius M. Amberson, MC (Ret.), died of pneumonia on 21 Oct 1988 at Walter Reed Army Medical Center. He was 93.

Dr. Amberson enlisted in the Navy during World War I and served as a radioman at sea. He was commissioned an ensign in 1918 and discharged 3 years later.

During the years between the World Wars Amberson followed two professions. As a consultant in mining engineering for 20 years, he was active in prospecting, drilling oil wells, and designing power plants. For 15 years concurrently he also practiced medicine.

During World War II Dr. Amberson rejoined the Naval Reserve as a commander, Medical Corps, serving with epidemiology units in the Middle East, Africa, India, and the Mediterranean.

In 1944 he pioneered the use of penicillin for treating smallpox as a means to promote healing with fewer scars. He accompanied naval units during the invasion of southern France that year, working in antibiologic warfare, malaria indoctrination, and preventive medicine in the field. He also had duty on an independent mission to the Middle East, India, East Africa, and South Africa, and collected medical intelligence there and in Egypt, Palestine, Lebanon, Turkey, Arabia, Iran, and Iraq. He was awarded the

Distinguished Service Medal for his work.

Dr. Amberson returned to BUMED (Naval Medical Command) in 1945, and 2 years later led a military medical expedition to Africa to study and treat tropical diseases. During the early 1950's he studied bubonic plague in Venezuela and cold weather medicine in the Arctic. He also served in Korea, and was medical officer in charge of "Operation Passage to Freedom," which involved the movement of more than 1 million refugees from North to South Vietnam.

Also during that decade Dr. Amberson lectured at Columbia University and while there helped develop a treatment for Chagas' disease, a tropical malady endemic in Central and South America. His

last assignment before retiring from active duty in 1959 was as medical officer of the 3rd Marine Division in Okinawa.

In 1963 Dr. Amberson worked for the National Science Foundation as civilian medical officer aboard the Navy ship *Eltanin* on a scientific expedition to the Antarctic.

Three years later he returned to active duty and was assigned to the Naval Medical School, where he directed the tropical medicine program. He retired yet again in 1970.

During his unique career Dr. Amberson became an active member of many organizations, some of which included the World Health Organization, the Arctic Institute of North America, and the American Polar Society.

NAVMEDCOM Archives



Dr. Julius Amberson (facing camera) and his comrades Dr. T.A. Dooley (left), PHC A.B. Cory, and LT E.H. Gleason work on a purification unit water pump at the La Pagode refugee camp near Haiphong.

Reminiscences of Passage to Freedom

Daniel M. Redmond

Amphibious Transport Division 13, CAPT Walter C. Winn commanding, was operating with marines on Okinawa at the beginning of August 1954. It was the division's third landing exercise since deploying to WESTPAC early in the year.

I was a reserve lieutenant junior grade on Winn's staff as intelligence officer, and had been briefing him regularly about Indochina. For a time in early spring we were sure the United States would enter the war. But in May Dien Bien Phu fell, the Geneva peace talks ended 2 months later, and in a few days the final cease-fire would go into effect in the north where most of the heavy fighting had occurred. It appeared that any direct American involvement in the French colony was behind us.

Suddenly on 8 Aug COMNAVFE canceled our exercise and ordered us to return to Japan. TRANSDIV 13 was to join CTF 90 in evacuating refugees from northern Indochina. CAPT Winn would take command of Task Group 90.8 upon arrival at Haiphong, the port city of Hanoi, located on the Cua Cam River in the Red River Delta.

By 15 Aug TRANSDIV 13 was at sea enroute to Haiphong. On 17 Aug in Indochina, the first naval ship, USS *Menard* (APA-201), carrying 1,924 refugees embarked from the Haiphong area, just 9 days after the initial American decision to assist had been conveyed to Vietnamese officials. By the time we arrived at Baie d'Along in the Gulf of Tonkin on 23 Aug, Winn had

selected five officers and 10 enlisted men to be the nucleus of his staff for the embarkation phase of what was to be called Passage to Freedom.

The next day we transferred to an APD, a small destroyer escort used to carry frogmen during amphibious operations. USS *Cavallaro* (APD-128), and at later stages two replacements, became the station ship and home of nearly all the staff of about 130 officers, sailors, and marines. The French would only permit the officers of the Preventive Medicine and Sanitation Unit (TU 90.8.6) to live ashore at a hotel in Haiphong while we were there.

Transfer completed, *Cavallaro* raced up the reddish waters of the Cua Cam. Occasionally, on the river's low banks we saw small concrete block-houses each flying the tricolor against a luminous azure sky. It was very hot and humid. Everyone was edgy because CTF 90 had warned that a resumption of hostilities could occur at any moment. We arrived at Haiphong and moored to buoys a short distance upriver from the small French naval base.

Immediately *Cavallaro* lowered a boat away with an armed crew to provide a 24-hour security patrol around the ship. Happily for the crews, who had to work in very tough conditions, Winn discontinued the patrol as soon as someone questioned how a Viet-minh sapper could swim in a current that often exceeded 4 knots.

Several hours after our arrival, Winn assumed command of CTF 90.8, and we began our embarkation duties. The

Cua Cam was dredged to only 20 feet so shipping was limited to vessels of less than 10,000 tons displacement. Consequently, we used U.S. and French amphibious craft (LST, LSM, LCU, LCI) as lighters, loading them with refugees for the trip down river to the Do San anchorage in Baie d'Along. There they would go alongside waiting APA's, AKA's, LSD's, TAP's, TAK's, and crews would move the refugees to the larger ships often with great difficulty.

The trip south took about 2½ days of intense discomfort for crew and passengers. At first Saigon was the drop-off point but overcrowding quickly shut it down. Cap St. Jacques on the South China Sea coast then became the landing site.

Movement from Haiphong had to be on an ebbing tide with enough time to ensure offloading in daylight at the anchorage. Night operations there were impossible because of heavy swells, frequent rain squalls, and the terror of the refugees. Although the Baie was only 10 miles away the trip took about 4 hours. Conditions on the Cua Cam were hazardous to unsure piloting, and ships moved cautiously to avoid collision and running aground. Moreover, once an LST left the river it still had a lot of water to cover before it reached the anchorage.

Besides Vietnamese we also had to remove large stocks of U.S. military equipment and ammunition delivered to the French in the later stages of the war. We used MST's (American officers, Japanese crews) and time-chartered merchant ships of less than



Doctor dispenses antimalarial pills in the La Pagode refugee camp.

10,000 tons. Pier availability and stevedoring problems in Haiphong really complicated this side of the operation. Nevertheless, the Navy left nothing behind when it finally pulled out of the north in May 1955.

At Tourane (now Da Nang), located on the coast almost halfway to Saigon, CTF 90 established a logistics center. On the return trip to Haiphong a ship would put in to Tourane to refuel, reprovision, and receive needed repairs. When the northwest monsoon disrupted the anchorage CTF 90 moved the center to the Baie d'Along.

For loading refugees we employed a site called *La Briqueterie* about a mile upriver from Haiphong. Here a number of two-story and smaller stucco buildings barracked a Foreign Legion company that, surprisingly, included at least a squad of Vietnamese prostitutes. The Geneva Accords restricted the introduction of additional military forces so the French said we could have only 15 officers and men at the site at any one time, a constraint they later relaxed. They also refused to allow us ashore with weapons, but they did promise Legion protection wherever we loaded refugees at the main site, *postes* on the river, or at nearby Hongay, a coal producing center.

This turned out to be the case. But we always had one lasting complaint: our defenders often vanished down the road in their trucks a lot sooner than we wished. Once they left three enlisted men and me uneasily waiting for a boat in a lovely spot. Long after

they were gone we had to listen to the threatening sounds of a very close but unseen fire fight. We were very relieved to see our boat about an hour after the firing ended.

In the early days of the operation the boarding area was very muddy from the intermittent heavy rains that drenched the Delta day and night. Falling in torrents, the rain actually hurt when it hit you. And, strangely, often you saw the Sun shining through it. Many times I stood in the rain, eating C rations that must have been packed in the early 1940's, mud to my ankles, rain and green dye from my cheap French army raincoat running into my shirt, marveling at my new, surprising life as a naval officer.

At first the loading site, a cleared area about 100 yards wide and 50 deep in front of the buildings leading down to the river, proved too narrow for orderly operations. French tanks hemmed in the space on both sides. We had a long, frustrating talk with the senior military officer, a major general who flabbergasted us when he said he had to get clearance from Saigon to move his tanks back a short distance on each side. CAPT Winn finally persuaded him to widen the work area without consulting higher authority. Even widened, the site retained a crowded look because of large medical tents, parked vehicles, and numerous people.

Every morning military trucks jammed with refugees would arrive from Camp de la Pagode, the primary holding location just outside Haiphong. Shouting "*allez . . . allez*," the Legionnaires herded them forward, prodding them with rifles to move faster. The refugees were silent, not knowing what was in store, frightened by the soldiers and us. After all the Vietminh had said we would take them to sea and dump everyone overboard except the females we planned to sell to army brothels in the south. As for the soldiers the refugees knew them all too well to trust them about anything.

The refugees were dressed in loose black cotton tops and trousers, most adults wearing yellow palm-leafed

cones or thick, dark head bands. They were nearly all women, children, and old men, many barefooted and they shuffled between wooden control barriers in white clouds of DDT dust. The first time you got close to them you gagged, but somehow with time we came to tolerate their smell. Our corpsmen moved among them giving what help they could. It was not always accepted. Trying to help a woman in labor one wet day, two corpsmen were frantically waved away as she delivered the baby on the muddy ground, washed it in the river, and walked aboard a French LSM.

Once they were through delousing, a ship waited for them at water's edge, bow door open, ramp down. On the first day Winn had made me embarkation officer, a role I played for much of our stay there. As the refugees passed me in single file, looking straight ahead, never smiling except for a rare child, a bosun clicked them off on his counter. We never got used to the misery we saw each day as thousands shuffled by holding their few belongings tightly or carrying them on *balanceurs*, the thin pole, bundle dangling from each end, seen everywhere in Southeast Asia.

They squatted on the well deck. Some tried to light cooking fires in braziers, but crewmen easily extinguished them. Occasionally a fire would go undetected until the caramel smell of burning opium alerted sailors. Besides the real fire danger, drug use on board violated naval regulations and panicked some ships to send messages like PAX SMOKING OPIUM ON BOARD X WHAT SHOULD WE DO. CTF 90 quickly ordered the ships to confiscate the drugs until debarkation at which time they were to be returned. Opium and hashish use was uncontrolled in Indochina, so we did not destroy them on discovery.

It was very crowded on the well deck. We did not separate families or villagers. Once having only an LST available we boarded about 3,000. Although such crowding made the trip to the Baie an arduous one, we did keep together a number of contiguous vil-

lages as requested by their chiefs and Catholic priests.

The Red River Delta is beautiful. The Baie d'Along, is spectacular with its turquoise waters specked with hundreds of limestone eruptions, some 500 feet tall. Unfortunately, the climate is tropical. Temperatures always seemed to be in the nineties or higher with 100 percent humidity. Even the river temperature was 96°. On the station ship berthing spaces below the water line were like steam baths, making uninterrupted sleep impossible. There was really not enough room to sleep on deck, and it rained during the night anyway. But still people tried it every night.

The French delivered water to the ship by barge three times a week. Our doctors added so much chlorine that it tasted like a swimming pool. Strict water rationing was the rule. Everyone seemed to suffer from skin rash, the worst case being the ship's baker who had to be evacuated because his whole body was covered with eruptions. And to make matters worse, the extra people on board only intensified the "town-gown" friction between crew and staff.

Morale was terrible. Not only were living conditions bad, we could not offset them with liberty. Even after the French allowed more of us on the beach we could not solve the problem. CTF 90's liberal liberty policy stopped at the 17th parallel. There would be no liberty north of there. As a result only 15-20 of us working got ashore every day—the embarkation party, the medical unit, and a few officers in Haiphong on official business. The rest were virtual prisoners aboard the station ship.

After senior petty officers began to show signs of stress we had to do something. To everyone's relief a clever staff officer came up with the "work party solution." If liberty parties were not allowed, we would put "work parties" ashore. The next morning an officer took 15 men ashore in their work

clothes—dungarees, blue shirt, and white hat. At the navy base he briefed them on Haiphong's very real dangers, emphasized their obligation to make the plan work for all, and told them to meet him back on the base at 1500.

In all the "work parties" that followed no one ever embarrassed us, and only one, a second class bosun, returned to the base and then went back into town. Two marines and I found him that night just before curfew drunk and jolly at *Le Sphinx*, the French army brothel in Haiphong.

On 25 Aug CTF 90 established Task Unit 90.8.6, the Preventive Medicine and Sanitation Unit, at Haiphong. Headed by CDR Julius M. Amberson it consisted of three medical officers, one Medical Service Corps officer, and four corpsmen. Among the doctors was LTJG Thomas A. Dooley, who later became famous for his books and speeches about Passage to Freedom and his subsequent medical missions in Southeast Asia.

Under Winn's command CDR Amberson was to coordinate with French and Vietnamese officials all medical matters relating to the embarkation. In addition his unit was to provide medical and sanitation assistance to evacuees.

Disease was widespread and shocking. Malaria, trachoma, smallpox, typhoid, worm infestation, fungi of all sorts, yaws, tuberculosis, dysentery, beriberi, rickets, conjunctivitis, pneumonia, measles, impetigo—we saw them all at Camp de la Pagode and the embarkation site. Refugees died at the camp, the site, and on the ships. Clearly France had been indifferent, or worse, to the medical needs of the people it had exploited for a hundred years.

Dr. Amberson and his unit, assisted by Vietnamese medical teams, did all they could to deal with the enormous health problems they found in Pagode. The unit also took care of our medical needs which, fortunately, were not too demanding. And they treated other Americans in the area—MAAG personnel, diplomats from Hanoi, the civilian pilots of Civil Air Transport (CAT) Co., an airline rumored to be partially funded by the CIA. The CAT pilots, a wild bunch of mercenaries, were famous with the French for their bravery in dropping supplies to the beleaguered garrison at Dien Bien Phu.

Besides the usual medical services the unit set up a complete epidemiological laboratory that included bacteriol-



Refugee cooking a meal.

A corpsman from the beach unit treats a child's sores in the La Pagode camp.

ogy and parasitology. One afternoon I spent several hilarious hours with Dooley and a corpsman trying to capture a couple of monkeys in the garden of the Continental Hotel so they could get samples of simian body lice.

Admiral Querville, the senior naval officer in the north and very friendly toward us, gave Amberson the use of a small two-room building on the naval base for the medical unit's headquarters and laboratory. A refrigerator came with the building, and the doctors kept blood samples, etc., and an ample supply of *Trente-Trois*, the very good local beer. Dr. Amberson had issued an open invitation to stop by if you were on the base. It became the only place in northern Indochina you could get a cold beer. It goes without saying that wine and beer were the only liquids you could drink with impunity in Haiphong.

Dr. Amberson was an internationally known expert on tropical and arctic medicine. When he came to Haiphong he was 59, easily the oldest American in the north. At least 6 feet tall he was overweight with a large belly. His face was fleshy and ruddy, his thinning hair white and brushed straight back. Amberson's clothes somehow seemed more rumpled than ours, and he liked to wear a *chapeau Breusse*, a wide-brimmed hat with the right side fastened to the crown in the manner of an Australian soldier.

A fine officer, Dr. Amberson was a very friendly man, smiling often and usually in good spirits. He wore his fame modestly and every one was quite fond of him. The night we received the ALNAV announcing his selection for captain two of us went over to Haiphong to tell him. Sure it gave us a good excuse to get off the ship, but it also gave us the opportunity to deliver agreeable news to a good guy.

At the boarding site he was very helpful in keeping us informed as to what we were seeing among the refu-



gees. Unlike most of us he did not seem too surprised at the signs of French neglect. He used to say, "Give us enough bars of soap and clean water, by God, we could get rid of about half these diseases." Watching mothers give new-borns their first bath in the filthy waters of the Cua Cam he often wondered out loud at the slim prospects of the babies reaching their first birthdays. Shortly after his selection to captain he received orders that took him out of Haiphong at the end of September.

As the weeks went by the operation slowed, and COMNAVFE started to return ships to normal training exercises. By the end of October most of the Navy was gone. A small staff headed by a commander stayed aboard the station ship, and Dr. Dooley remained in Haiphong with five corpsmen. Refugees continued to depart on time-charted merchant ships. In May 1955 Passage to Freedom ended, and the few remaining Americans departed the north.

By any standard the operation was a success. During the 9 months we transported by sea 310,848 refugees (including 17,846 military), 68,757 tons of equipment and ammunition, and

8,135 vehicles. According to Bui Van Luong, the former General Director of the Refugee Commission, the French and Americans evacuated a total of 768,672 refugees, 555,037 by ship and 213,635 by French airlift. Others left the north on foot or by boat. In all 928,152 went south, the vast majority of whom were Catholics.

In mid-October the American ambassador in Saigon sent a message to CTF 90 that he in turn passed on to all the units involved in the evacuation. Ambassador Heath summarized the operation as follows:

UPON OCCASION YOUR DEPART FROM SAIGON WOULD LIKE TO REITERATE MY ADMIRATION FOR WAY IN WHICH YOU HAVE CARRIED OUT MISSION CONNECTION EVAC REFUGEES FROM NORTH X CONDUCT YOUR OFFICERS AND MEN BOTH AFLOAT AND ASHORE DESERVES HIGHEST COMMENDATION X FOR THEIR KINDNESS AND THOUGHTFULNESS TOWARDS REFUGEES HAVE LEFT IMPRESSION OF INDIVIDUAL AMERICANS WHICH WILL NOT SOON BE FORGOTTEN X MISSION HAS BEEN CARRIED OUT IN BEST TRADITION OF NAVAL SERVICE X □

Mr. Redmond practices law in Washington, DC.

Food Handlers

A Potential High Risk Group for Hypercholesterolemia

LCDR Rodney W. Savage, MC, USN
 LCDR Kenneth Lee, MC, USNR
 HMCS Charles Conklin, USN
 LT Stephen J. Boccuzzi, NC, USNR

Treatment of hypercholesterolemia reduces both fatal and non-fatal myocardial infarctions,^(1, 2) and may slow progression of coronary atherosclerosis.⁽³⁾ Cholesterol determinations are frequently ordered during routine physical examinations leading to obvious opportunities for individual patient management. Such testing also provides the medical officer with data which, when analyzed, may identify important occupational risk groups worthy of organizational intervention and followup. We present one such analysis, and outline our ongoing clinical approach.

Methods

Review of randomly drawn fasting cholesterol determinations seemed to show an increased frequency of high values in the enlisted personnel of the White House Staff Mess. Accordingly, fasting cholesterol determinations of all 59 members of the White House Staff Mess were abstracted from available health records. All values had

been determined by the laboratory at Naval Hospital, Bethesda, MD, using the cholesterol oxidase method [American Monitor Enzymatic Cholesterol ST Reagent System].⁽⁴⁾ The mean of normal cholesterol values using this method was 195 mg/dl, with

a range of 145 mg/dl to 245 mg/dl at 37°C.

Laboratory internal quality control during the period in which determinations were made showed a coefficient of variation of 3 percent.⁽⁵⁾ Results from the combined group were com-

TABLE 1
White House Staff Mess Group Characteristics

Group	Total	Food Handlers	Nonfood Handlers
n	59	33	26
Age (years)	40	40	40
Sex			
Male	56	32	24
Female	3	1	2
Race			
Malaysian	48	28	20
Other	8	4	4
Type II diabetes mellitus	4	2	2

TABLE 2
White House Staff Mess Cholesterol

Group	Total*	Food Handlers**	Nonfood Handlers**	Laboratory Reference*
n	59	33	26	
Cholesterol (mg/dl)	211.2	225.4	193.2	195.0
Standard deviation	43.5	46.2	32.4	50.0
Standard error	5.7	8.0	6.4	3.0**

* p = 0.01

** p = 0.004

pared to normative data using the Student's t-test.(6) The total group was then divided into food handlers and nonfood handlers. These groups were then compared to one another, again using the Student's t-test.

Results

Total group (n = 59) mean cholesterol was 211.2 mg/dl compared to the laboratory mean cholesterol of 195 mg/dl (t = 2.3, p = 0.01). Food handlers (n = 33) showed a mean cholesterol of 225.4 mg/dl versus nonfood handlers (n = 26) with a mean cholesterol of 193.2 mg/dl (t = 3.0, p = 0.004). The groups were similar in age, race, sex, and incidence of controlled type II diabetes mellitus (see Tables 1 and 2).

Discussion

The data confirmed that White House Staff Mess workers had a higher mean cholesterol than the normal population of the laboratory at Naval Hospital, Bethesda. More importantly, subgroup analysis showed that nonfood handlers had normal mean cholesterol while foodhandlers had elevation of mean cholesterol of robust statistical significance.

With an estimated 2 percent reduction of cardiac events for each 1 percent reduction of serum cholesterol, (2) the identification of such potentially job-related high risk subgroups assumes obvious importance.

Whether increased cholesterol in these food handlers is due to increased dietary intake or to altered composition of dietary intake is not known. Such questions may be partially answered by performing detailed, computerized dietary audits and examining height, weight, and percent body fat of these workers. Should significant differences emerge, a risk factor modification program of dietary education, weight reduction, re-education, and followup may result in a significant reduction in cholesterol levels. If not, perhaps job restructuring measures would prove effective. Such measures could include menu changes, strict rules against "snacking" while on the job, and possible reassignment to nonfood handling work.

Ultimately, drug therapy may prove necessary in some workers. A voluntary program based on these considerations has recently been offered to the workers of the White House Staff Mess. This will offer the opportunity for more thorough baseline assessment and lipid characterization with followup at intervals after each level of intervention.

Conclusion

Using readily available data and simple statistical methods, it has been shown that the food handlers of the White House Staff Mess have significantly higher mean cholesterol than

nonfood handlers. This difference is not attributable to differences in age, race, or sex, but may be due to on the job differences in food intake (quantity and/or type of food). Planned further study and nondrug intervention in this group is warranted. Similar study of potential risk groups in other operational settings is recommended.

References

1. The Lipid Research Clinics coronary primary prevention trial results: I. Reduction in incidence of coronary heart disease. *JAMA* 251:351-364, 1984.
2. The Lipid Research Clinics coronary primary prevention trial results: II. The relationship of reduction in incidence of coronary heart disease to cholesterol lowering. *JAMA* 251:365-374, 1984.
3. Brensike JF, Levy RI, Kelsey SF, et al: Effects of therapy with cholestyramine on progression of coronary atherosclerosis: Results of the NHLBI type II coronary intervention study. *Circulation* 69:313-324, 1984.
4. Ellefson RD, Caraway WT: *Fundamentals of Clinical Chemistry*. NW Tietz (ed), Philadelphia, WB Saunders Co, 1982, pp 509-510.
5. Klym D: Personal communication, 30 March 1987.
6. Colton T: *Statistics in Medicine*. Boston, Little Brown & Co, 1974, pp 131-142. □

When this article was written Dr. Savage was a White House Physician assigned to the White House Medical Unit, Washington, DC 20500. Dr. Lee was previously assigned as a White House Physician. HMCS Condlin was assigned to the White House Medical Unit. LT Boccuzzi is on the staff of the Department of Medicine, Uniformed Services University of the Health Sciences, Bethesda, MD 20814-4799.

PMT of the Year Award Established

The Navy Environmental Health Center in Norfolk, VA, recently announced the establishment of the Stephen W. Brown Award, named in honor of retired HMCM Brown, a former preventive medicine technician (PMT), who had a particularly distinguished Navy career from 1952-1986. HMCM Brown saw service in Korea and Vietnam; was assistant training officer and senior instructor, Preventive Medicine Technician School; and Command Master Chief, Naval Regional Medical Center, Oakland, CA. He also was the first enlisted Director of the Hospital Corps and served as Master Chief Petty Officer of the Force.



HMCM Brown (Ret.)

The purpose of the award is to recognize individual PMT's around the world for sustained professional excellence and contributions to the Navy occupational health and preventive medicine program.

The Stephen W. Brown Award and two other new awards, the Ernest Brown Award, given for excellence in occupational medicine, and the Charles Stephenson Award, given for excellence in preventive medicine, will be presented at the Navy Environmental Health Center's Workshop scheduled 11-16 March 1989 at Virginia Beach, VA.

New Dental Corps Director

RADM Milton C. Clegg, DC, became the 29th Chief of the Dental Corps on 27 Jan 1989 succeeding RADM Richard Shaffer. Born 1 Sept 1933 in Salt Lake City, UT, Dr. Clegg graduated from the University of Utah in 1956 with a B.A. in experimental biology. Upon graduation in 1960 from the Baltimore College of Dental Surgery, University of Maryland, he received his doctorate in dental surgery. He also is a graduate of the 1-year course in general dentistry at the Naval Dental School, Bethesda, MD, and holds a M.S. degree in systems management from the University of Southern California.



RADM Clegg

RADM Clegg was a freshman in dental school when he

was commissioned an ensign in the Naval Reserve. Immediately following graduation, he reported for active duty to Marine Corps Air Station, Kaneohe Bay, HI, as a lieutenant junior grade. Since then he has remained on continuous active duty and was augmented into the regular Navy in 1963. He was promoted to rear admiral (lower half) in December 1988.

Dr. Clegg has since served in many sea, shore, and operational assignments. He is a member of the American Dental Association, Academy of General Dentistry, Association of Military Surgeons of the United States, and Federation Dentaire Internationale. He is an honorary member of the Republic of Korea Military Medical Society, and has been cited twice by government agencies of the Republic of Korea for sustained contributions to dental public health and community relations programs (1970-1972). Dr. Clegg is also a fellow in the International College of Dentists.

RADM Clegg wears the Legion of Merit, Meritorious Service Medal with gold star, Navy Commendation Medal, Navy Unit Commendation Ribbon, Navy Expeditionary Medal, National Defense Service Medal, Armed Forces Expeditionary Medal, Vietnam Service Medal with two bronze stars, Sea Service Deployment Ribbon, Navy and Marine Corps Overseas Service Ribbon, and Republic of Vietnam Campaign Medal with device.

AMSUS Convention: Call for Abstracts

Abstracts are being sought for a Navy multidisciplinary research poster session to take place at the 96th annual Association of Military Surgeons convention in San Diego, CA, 12-17 Nov 1989.

Eligible active duty or reserve entrants are Navy Medical, Nurse, Medical Service, Dental, and Hospital Corps personnel who are listed as the first author on the abstract. Research topics may focus on any issue related to health and illness, including but not limited to basic bench research, pathological processes, health promotion, disease prevention, health care delivery programs/systems, and health education.

Abstract content should include: (1) statement of scientific problem (purpose, hypotheses, significance); (2) methodology (design, sample size, methods for data collection and analysis; and (3) findings (major findings, conclusions, recommendations). Abstract must be of completed research and is not to exceed 350 words. Four copies should be provided including the names and ranks/rates of investigators, institutional affiliations, and mailing address/telephone number of first author.

Deadlines for submission is 31 May 1989. Abstracts should be mailed to: AMSUS, 9320 Old Georgetown Road, Bethesda, MD 20814. ATTN: Linda Hines.

Distinguished Author Award

Proceedings, the publication of the Naval Institute, recently announced CAPT Arthur M. Smith, MC, USNR, the recipient of their Distinguished Author Award. Dr. Smith, professor of surgery (urology) at the Medical College of Georgia, is a prolific contributor to *Proceedings* and *Navy Medicine*. His provocative articles on the state of Navy medicine include "No More Band-aids," *Proceedings*, February 1988; "Blood on the Deck," *Proceedings*, July 1988; "Safeguarding the Hospital Ships," *Proceedings*, November 1988; and "Getting Them Out Alive," *Proceedings*, February 1989. Dr. Smith's *Navy Medicine* articles include "Conceptual Errors in Combat Casualty

Care Training: How to Reverse Them," and "Fire at Sea: Critical Burn Management Considerations in a Small Deployed Surface Combatant."

Scientific Experiments

The Massachusetts Institute of Technology (MIT) will offer an elementary course titled "Design and Analysis of Scientific Experiments," 10-15 July 1989. Applications will be made to the physical, chemical, biological, medical and industrial sciences, and to experimentation in psychology.

Further information may be obtained by writing to: Director of Summer Session, Room E19-356, MIT, Cambridge, MA 02139.

To the Editor

I've just read an article on page 28 of the September-October 1988 issue of *Navy Medicine* which states that CDR Margaret Balacki, NC, USNR, was the second woman and the first staff corps officer to be selected as commanding officer of a Naval Reserve Readiness Unit. While she may be the second woman in such a billet, she is *not* the first staff corps officer. The honor belongs to CAPT Lon D. Carroll, DC, USNR, of Gresham, OR, who, on 1 Oct 1987, assumed command of Naval Reserve Readiness Unit 2206 at the Naval Reserve Readiness Center, Portland, OR.

RADM J.R. Hubbard, DC, USNR

Having just finished reading the article in the November-December 1988 issue of *Navy Medicine* titled "First Female IDC Delivers Health Care," we are compelled to write and urge that the record be set straight.

On behalf of the *many* female IDC's that have gone before HMC Kildow and worked *independent of a medical officer* at isolated CONUS as well as overseas and ship-board stations, we find this article not only misleading but belittling to those of us who have worked under arduous conditions without the help of any medical support.

HMC Kildow is by *no means* the first female IDC to deliver health care in the United States. It also should be noted that not all other IDC's are assigned to ships. There are isolated shore billets filled by female IDC's at San Nicolas Island, San Clemente Island, and in the past, Pacific Beach, Washington to name a few. These billets have long been filled by female independent duty hospital corpsmen.

Credit is due for her recent credentialing but to print that she is the first female IDC and the first IDC to practice while on shore duty in the Continental United States is false. Furthermore, she was given the benefit of an assistant as well as a contract civilian physician. Those of us that have been on true independent duty were not afforded that luxury.

We feel that story should be corrected to reflect the sacrifices that previous female independent duty corpsmen have made and will continue to make in the years to come. Let's give credit where credit is due.

HMC M.P. Arp
HMC(AC) D.K. Heath
HMC R.A. Grogan

I have just finished your excellent series on IDC corpsmen in the November-December 1988 issue of *Navy Medicine*, and wish to commend you on giving some positive feedback to the hardest working corpsmen in the U.S. Navy.

However, your article on HMC Kildow was inaccurate. Here, at the Naval Hospital Branch Clinic, Mayport, FL, during the period of February 1988 to December 1988, HMC Henry F. Sexauer, a superb example of the best qualities any IDC could possess, was credentialed as a Health Care Provider and performed "hands-on" patient care. This period, I believe, would also make him one of the first IDC corpsmen credentialed for direct health care in CONUS.

CWO4/PA-C P.R. Decommer
CWO4/PA-C P.E. Crowl

***Navy Medicine* Seeks Articles and Photos**

Navy Medicine is seeking articles of widespread interest to all or part of the Navy Medical Department for future issues from readers. As you know, our magazine's constituency and our range of contributors cover the waterfront—physicians, dentists, nurses, MSC officers, corpsmen, dental techs, physician's assistants, and civilian staff.

Over the years we have always encouraged our readers to submit articles in the areas of their expertise or experience, and have grown to rely on our "eyes" in the field and in the fleet to report current news, professional developments, and commentary on medically-related subjects, clinical and otherwise.

Timely, well-written, and well-illustrated stories of broad interest are strong candidates for publication. As you undertake new or improved procedures, or practice unique and interesting medicine, share your work and experience with your colleagues and get the reward of published professional visibility by writing an article.

Editorial Guidelines

Text

Submissions should be typed and double-spaced from 1,000 to 2,000 words (two copies). Please be sure to include the full name, rank, and affiliation of author or authors, and a contact telephone number and military address.

Illustrations

Photos should, wherever possible, be 8" x 10" black and white, captioned, and with the photographer noted for credit purposes. Quality photography is essential. Snapshot photos, polaroids, or those not properly focused and exposed cannot be used. Exceptional photos related to any aspect of Navy/Marine Corps medical practice are always in demand for cover use. No color slides or large transparencies please.

Tables and figures should be fully marked and camera-ready. References must be properly footnoted, and the manuscript should have a bibliography if outside sources were used. For the proper format, consult a recent copy of *Navy Medicine* or request a copy from us.

Deadlines for articles submitted in 1989 are:

For the May-June issue	1 March
July-August	1 May
September-October	1 July
November-December	1 September

Contact: Jan K. Herman, Editor, *Navy Medicine*

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